Herefordshire Council

Minutes of the meeting of Adults and wellbeing scrutiny committee held at online meeting only on Monday 21 September 2020 at 2.30 pm

Present: **Councillors Elissa Swinglehurst (Chairperson), Jenny Bartlett (Vice-chairperson), Sebastian Bowen, Helen l'Anson, Tim Price, David Summers and Kevin Tillett**

Councillors in attendance:	Councillors Pauline Crockett (Cabinet member - health and adult wellbeing), Yolande Watson (Cabinet support member - adults and communities)
Officers:	Head of community commissioning and resources, Democratic services officer, Senior commissioning officer, Democratic services manager, Deputy solicitor to the council, Governance support assistant, Assistant director all ages commissioning, Director for adults and communities and Director of public health
Others in attendance:	Christine Price (Healthwatch Herefordshire)

1. APOLOGIES FOR ABSENCE

All committee members were present.

Apologies were noted from Councillor David Hitchiner (Leader of the Council) and Dr Ian Tait (Chair of NHS Herefordshire and Worcestershire Clinical Commissioning Group).

2. NAMED SUBSTITUTES (IF ANY)

There were no substitutes.

3. DECLARATIONS OF INTEREST

No declarations of interest were made.

4. MINUTES

The minutes of the last meeting were received.

Resolved: That the minutes of the meeting held on 2 March 2020 be approved as a correct record and be signed by the chairperson.

5. QUESTIONS FROM MEMBERS OF THE PUBLIC

No questions had been received from members of the public for this meeting.

6. QUESTIONS FROM COUNCILLORS

A question received from Councillor Tillett and the response provided by the consultant in public health, and a supplementary question asked by Councillor Tillett under this item and the response provided by the director of public health (during the following agenda item), are provided in an appendix to these minutes.

7. SUICIDE PREVENTION STRATEGY IMPLEMENTATION

The committee received a presentation from the head of community commissioning and resources (HCCR) on suicide prevention, as included in the appendix to the report. The principal points included:

i. Suicide prevention had been a national priority for a number of years and, whilst local authorities led on this, it involved a whole system / multi-agency approach.

ii. The national policy position, that all suicides are potentially preventable, was embraced locally.

iii. The most recent official data (2018) showed significant increases in completed suicides nationally, particularly for people under 25, but this was not replicated locally, where there was a slight downward trend overall, with the same number of deaths in 2017 and 2018.

iv. Demographically, nationally and locally, men aged 35-64 were at greatest risk of suicide. There was high representation of farming / construction sectors. There was also higher incidence in areas of greater deprivation.

v. Hanging was the most commonly used method in completed suicides.

vi. There was a significant change evolving in the way in which coroners recorded suicide, moving away from the traditional criminal standard of proof (beyond reasonable doubt) and towards the civil standard (the balance of probabilities).

vii. Interpreting and understanding suicide data was complicated by the relatively low numbers locally and the time that could elapse before confirmation of death by suicide was received.

viii. The 'Herefordshire Suicide Prevention Strategy 2019-2023' had been approved by cabinet in July 2019 and included the key priorities of: communities; media; bereavement information and support; reducing the means of access to suicide; reducing the risk of suicide for high risk groups; mental health services; and self-harm. These reflected national priorities, apart from the inclusion of 'communities' which reflected the local approach to working with communities on prevention.

ix. An action plan had been developed in conjunction with a number of organisations and groups. Although the process had been affected by the Covid-19 emergency, good progress had been made in some areas. It was commented that, anecdotally, there could be an increasing risk of suicides occurring in Herefordshire but this could not be verified without further intelligence.

x. There was good work emerging with a number of voluntary groups, including national groups such as Survivors of Bereavement by Suicide and PAPYRUS, and local groups such as the CLD Trust. There was a great deal of potential for multi-agency effort, with interest from the Primary Care Networks and the emergency services.

xi. Real time data (RTD) was a key issue that had been made a national priority. It was anticipated that an RTD capture arrangement, in collaboration with the emergency services, would be established before the end of the year. There were compelling reasons to take this approach, such as directing bereavement support quickly and appropriately; people bereaved by suicide were more likely to feel suicidal themselves, with around 9% making a suicide attempt. This would also

enable patterns and emerging trends to be identified. The sensitivities to be managed, including the potential for suicide not to be recorded by the coroner ultimately, were noted.

xii. 'Wave 3' funding for suicide prevention in Herefordshire and west Worcestershire had been secured, with a new project team being recruited. In Herefordshire, the focus was on rural/farming communities and men. Work was ongoing with groups such as Borderlands Rural Chaplaincy and the National Farmers Union. Broader work was also taking place with other sectors, such as the military, voluntary and community groups, and the NHS.

xiii. Covid-19 may have an escalated risk of suicide but this was not yet clear nationally or locally. There may also be escalated risk associated with financial hardship, potentially relating to Covid19 or Brexit.

xiv. The Mental Health Partnership Board was helping to oversee and drive forward this work, with positive engagement from various agencies.

xv. Talk Community hubs had expressed interest in suicide prevention as a priority.

xvi. Attention was drawn to some of the available training and resources, including online awareness training.

The chairperson welcomed the report and presentation, and made a number of comments, including: suicide was a difficult but important subject; the strategy had good elements but the sense of progress was indistinct, especially as the action plan had only been summarised in the meeting papers; the coronavirus pandemic could be creating additional contributing factors to risk of suicide and there may be a need for urgency in the delivery of some of the ambitions within the strategy; it was questioned who was responsible for the monitoring of the delivery of the strategy; it was pleasing that progress was being made with RTD, especially in view of the potential to support the bereaved, and links with first responders would be critical to this; and suicide was not just an epidemiological phenomenon and was a broader issue for society.

In response, the HCCR reported: there had been significant progress; there was a detailed action plan which was in the process of being updated and would be circulated to committee members; the strategy was overseen by the Mental Health Partnership Board and one of its sub-committees, and would report to the Health and Wellbeing Board; there was good engagement with first responders and other key agencies to support RTD capture and effective prevention work; and it was acknowledged that progress against the action plan could be made more visible.

Questions and comments were invited from attendees, the principal points included:

1. A committee member questioned the progress over the past year and expressed disappointment with the hiatus in committee meetings. In response to a question, the HCCR advised that the Wave 3 funding had only been confirmed relatively recently. The committee member also expressed disappointment with the approach to mental health generally. In response to another question, the HCCR explained the background to the Mental Health Partnership Board and outlined its membership which included representation from the council, the NHS, volunteer groups and experts by experience.

2. A committee member questioned whether there was any information on rates of suicide among rough sleepers and for people with financial problems. The HCCR advised that it was difficult to determine underlying factors from the official data from the Office for National Statistics and without further interrogation of coroner's

reports; the benefits of RTD in gathering more detailed information at an earlier stage were noted. The HCCR said that he was not aware of any deaths by suicide of rough sleepers in recent times but this would be checked. The HCCR commented that, whilst there was impetus and effort nationally around suicide prevention, the focus was more on demographics rather on the underlying issues in people's lives. He added that this could be considered locally as a way of augmenting and strengthening the strategy. The chairperson noted that prevention was key but this required prediction, informed by risk factors and appropriate levels of data.

3. The vice-chairperson: suggested that the action plan should include details of who was leading on what action; questioned whether elements in the strategy referencing 2gether NHS Foundation Trust were now being picked up by the Worcestershire Health and Care NHS Trust; questioned what was progressing in terms of Talk Community and what was being achieved; noted that the remit of the committee included the scrutiny of the Health and Wellbeing Board and a more in depth look at the achievements of the strategy would be needed, perhaps in a year's time; and, referencing paragraph 7 of the report, sought clarification on the funding and focus 'on rural isolation and the farming community'.

   The HCCR advised that: the funding would support people experiencing rural isolation, including those in the farming community; Worcestershire Health and Care NHS Trust would continue the work as the successor body to 2gether NHS Foundation Trust in Herefordshire and an overview was provided on progress; work was continuing on opportunities through the Talk Community programme, informed by the material that had emerged in terms of broader mental wellbeing as part of the Covid-19 response and this would be informed further by the Wellbeing Survey to be undertaken in early 2021.

4. The chairperson commented on the need for consideration of the prioritisation of the work being undertaken on suicide prevention in light of Covid-19, with more people potentially facing financial and job insecurity and other pressures associated with the pandemic.

5. A committee member commented on the valuable work of faith groups in rural communities, including Borderlands Rural Chaplaincy. The HCCR reported on recent discussions on the potential for Talk Community to work with the Diocese of Hereford and its network of clergy and volunteers.

   The committee member also commented on the importance of early support and it was questioned how the priority 'reducing the means of access to suicide' could be delivered. The HCCR recognised that there were limitations in the capacity of services to intervene effectively in certain circumstances but it was anticipated that continued close working with the emergency services would help to identify locations and methods used in attempted suicides; it was reported that work had been undertaken on access to railways lines and further work would be considered on access to rivers.

6. The cabinet support member – adults and communities: noting that the statistics provided in the presentation related to 2018, questioned whether data was available for 2019; drawing attention to a point in the previous minutes that the 'IAPT (Improving Access to Psychological Therapies) access rate had improved but was below the national target' (minute 46, para q. refers), questioned whether the NHS was always best placed to identify people at risk of suicide; and suggested that, in view of the limited infrastructure in many rural wards, other local groups and settings could be approached such as parish councils, pubs, women's institutes, and young farmers' clubs.

The HCCR said that: data for the previous calendar year was usually published at the end of September, reinforcing the need for RTD; the NHS was a key partner but the strategy depended on a whole partnership approach, adding that one of the contradictions in this subject area was that people with a diagnosed mental health condition were at a higher risk of attempting suicide but the majority of people attempting suicide did not have a diagnosed mental health condition; and Talk Community was seeking to engage with a wide range of local groups and organisations.

The Senior Commissioning Officer provided an overview of an informal group that he had been involved with in a personal capacity in Golden Valley and noted the potential for local councils, especially following their involvement in Covid-19 response groups, to support people in their communities.

7. The chairperson commented on the value of simple messaging and suggested that information could be distributed to inform communities, families and friends about the signs that someone might be at risk of suicide. The chairperson also commented that soft intelligence could be sought proactively from family members, friends and close support networks in order to enhance understanding.

8. A committee member commented on the need to involve local councils and publicise related prevention campaigns; Hereford City Council's active support for a men's mental health group was noted. It was suggested that, given that Herefordshire did not necessarily follow some of the national trends and the particular challenges for people in rural areas, it would be helpful to make comparisons with other local authority areas with comparable demographics. It was commented that the traditional GP relationship was changing, with many patients attending practice hubs and seeing different GPs, therefore there should not be an overreliance on GPs to know patients well enough to identify concerns. It was also commented that neither the strategy nor the presentation mentioned the LGBT+ community and it was felt that this was surprising omission, especially in view of the key findings of a Stonewall report ('LGBT in Britain - Health', 2018) in relation to suicide and self-harm. Furthermore, the increased sense of isolation during the Covid-19 lockdown period may have resulted in a higher risk of suicide.

   The HCCR said that the point about the LGBT+ community was well made and he was not aware that this had been dealt with directly in the national strategic approach but this could be explored locally. It was commented that changes in GP interactions may have positive aspects and there was a promising degree of engagement from some of the Primary Care Networks. It was also commented that data comparisons with other local authority areas could be made but, in view of the relatively low numbers, there was a need for caution as apparent patterns and trends may not be reliable from a statistical perspective. He added that the fact that the county was part of the third wave of funding for suicide prevention demonstrated that there was a lower level of risk currently.

   In response to a further question, the HCCR clarified that the official data did not provide details in relation to suicide amongst groups with protected characteristics; this would require original research which could involve intelligence gathering from the bereaved, as suggested earlier in the meeting.

9. The chairperson commented that substance misuse may be another telling point of contact with the system.

10. Referencing Appendix A ('Summary of what we can do') to the strategy, the vice-chairperson questioned whether there were any key performance indicators or other metrics in development to measure progress.

    The HCCR advised that the action plan had been shared with the Mental Health Partnership Board and with partner agencies; it was reiterated that it would be circulated to committee members shortly.

    In response to a comment about the challenges around performance indicators, the vice-chairperson recognised the sensitivities in terms of suicide prevention but noted that the appendix to the strategy identified a number of potential actions, such as the provision of bereavement information and support, which could be measured. The HCCR said that the action plan would show where progress was expected and where it was being made. He added that the council recognised the importance of implementing the strategy, having instigated and coordinated its creation, but it did not have any specific resources to deliver all elements of the strategy itself and had limited ability to hold other agencies to account.

    In view of the resourcing issue, the vice-chairperson questioned whether some of the Wave 3 funding could be used to help drive delivery. The chairperson noted that there seemed to be a good action plan but felt that it required monitoring and implementation.

11. In response to a comment from the chairperson, the HCCR confirmed that Herefordshire Mind was a key partner; it was noted that the Safe Haven service had launched subsequent to the publication of the strategy.

12. The director of adults and communities said that: the points raised by committee members and the discussion had demonstrated some of the complexities of the system and some of its shortcomings; multi-agency strategies relied on partners working together, dedicating resources, and bringing focus to important topics such as this; the ongoing work to tackle wider health inequalities should not be underestimated, particularly in terms of the Talk Community programme which was working with communities to raise awareness around mental wellbeing and help people to access support and advice; awareness had to be part of every-day practice for a broad range of social care, health, and other practitioners; the comments about the changing patient / GP relationship potentially exposed a new type of risk which could be explored with clinical directors; and a standalone strategy or resource was not required, this was more about system response and management.

13. The cabinet member – health and adult wellbeing: welcomed the in depth discussion and committed to providing responses on the matters outstanding; noted that suicide prevention was a difficult and emotive subject but an important one, and there was a need to communicate clear messages about the help that was available; and invited member input and questions at cabinet in relation to the content of strategies under consideration.

The committee then discussed draft recommendations and agreed the following resolution.

Resolved: That the committee recommends to the executive:

(a) That the updated suicide prevention action plan is circulated to the committee with clear organisational leads identified against specific actions within the plan, including the role and responsibilities of the Mental Health Partnership Board; where it is possible and appropriate to

do so, to include the relevant Key Performance Indicators (KPIs) of where progress is expected to be made.

Noting the resource implications for monitoring the suicide prevention action plan, focus should be given to allocating resource from the Wave 3 funding to ensure that data and trends can be presented and reported on.

(b) Consideration is given to a re-prioritisation of our more vulnerable at risk groups as we enter into a more financially and emotionally challenging period.

(c) The committee is provided with the updated suicide data for 2019 once the new figures are available.

(d) That parish councils, faith groups and other local community points of contact are given information to share and are placed as central stakeholders in assisting the communication/signposting of information and advice about suicide prevention, sources of support and assistance.

(e) Consideration is given to comparing Herefordshire's suicide data with other comparable local authority area data to ascertain whether any patterns or trends can be identified that might strengthen our knowledge and targeted interventions in preventing suicides.

(f) Consideration is given to working with bereaved families and friends to gather soft data and intelligence to strengthen our knowledge of risks and factors that lead to suicide or attempted suicides.

(g) Due consideration be given to the LGBT+ communities in relation to assessing the support and interventions provided in supporting individuals and groups at risk.

(h) The new GP and patient relationship is changing and there is a need to work with the new Primary Care Networks on suicide prevention.

8. COMMITTEE WORK PROGRAMME

The chairperson noted that members had identified various potential items for future consideration and these now needed to be prioritised based on their impact, significance, timeliness and potential to lead to effective outcomes. It was reported that a work programming session was being arranged for scrutiny committee members during October 2020.

The chairperson drew attention to the schedule of recommendations and responses, made by the committee at the January and March 2020 meetings, and requested an update on the position with NHS Continuing Healthcare (CHC). On behalf of the assistant director all ages commissioning who had to leave earlier in the meeting, it was reported that the work on CHC had ceased during the past few months, as CHC itself as a funding stream was suspended between March and August. It was expected that the issue would be progressed now that the relevant teams were back in operation and an update would be provided to a future meeting.

Resolved: That consideration of the work programme be deferred to the work programming session for scrutiny committee members.

9. DATE OF NEXT MEETING

It was noted that the next scheduled meeting was Monday 23 November 2020.

The meeting ended at 4.46 pm **Chairperson**