Leicestershire County Council

Meeting: **Health Overview and Scrutiny Committee**

Date/Time: **Wednesday, 2 June 2021 at 2.00 pm**

Location: **Council Chamber, County Hall, Glenfield**

Contact: **Mr. E. Walters (0116 3052583)**

Email: **Euan.Walters@leics.gov.uk**

Membership

Mr. S. L. Bray CC
Mr. K. Ghattoraya CC
Mr. D. J. Grimley CC
Mrs. A. J. Hack CC
Mr. P. King CC
Mr. J. Morgan CC
Mr. C. A. Smith CC

Please note: this meeting will be filmed for live or subsequent broadcast via the Council's web site at http://www.leicestershire.gov.uk

AGENDA

Item		Report by
1.	Appointment of Chairman.	
2.	Election of Deputy Chairman.	
3.	Minutes of the meeting held on 18 March 2020.	(Pages 5 - 10)
4.	Question Time.	
5.	Questions asked by members under Standing Order 7(3) and 7(5).	
6.	To advise of any other items which the Chairman has decided to take as urgent elsewhere on the agenda.	
7.	Declarations of interest in respect of items on the agenda.	

8. Declarations of the Party Whip in accordance with Overview and Scrutiny Procedure Rule 16.

9. Presentation of Petitions under Standing Order 35.

10. Community Services and place-based plans. — Leicester, Leicestershire and Rutland Clinical Commissioning Groups

A presentation will be given by Leicester, Leicestershire and Rutland Clinical Commissioning Groups.

11. Ex HM Armed Forces: Spotlight on Mental Health Services. — Healthwatch — (Pages 11 - 28)

12. Suicide Prevention. — Director of Public Health — (Pages 29 - 34)

13. Date of next meeting.

The next meeting of the Committee is scheduled to take place on 1 September 2021 at 2.00pm.

14. Any other items which the Chairman has decided to take as urgent.

QUESTIONING BY MEMBERS OF OVERVIEW AND SCRUTINY

The ability to ask good, pertinent questions lies at the heart of successful and effective scrutiny. To support members with this, a range of resources, including guides to questioning, are available via the Centre for Public Scrutiny website www.cfps.org.uk.

The following questions have been agreed by Scrutiny members as a good starting point for developing questions:-

- Who was consulted and what were they consulted on? What is the process for and quality of the consultation?
- How have the voices of local people and frontline staff been heard?
- What does success look like?
- What is the history of the service and what will be different this time?
- What happens once the money is spent?
- If the service model is changing, has the previous service model been evaluated?
- What evaluation arrangements are in place – will there be an annual review?

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Agenda Item 3

Minutes of a meeting of the Health Overview and Scrutiny Committee held via Microsoft Teams video conferencing on Thursday, 18 March 2021.

PRESENT

Dr. R. K. A. Feltham CC (in the Chair)

Mr. D. C. Bill MBE CC	Mr. J. Morgan CC
Mr. J. G. Coxon CC	Mr. J. T. Orson JP CC
Mrs. A. J. Hack CC	Mrs. R. Page CC
Dr. S. Hill CC	Mr T. Parton CC

In attendance
Mr. L. Breckon JP CC, Cabinet Lead Member for Health, Wellbeing and Sport.
Kate Allardyce Senior Performance Manager, NHS Midlands and Lancashire Commissioning Support Unit.
Hannah Hutchinson, Assistant Director of Performance Improvement, Leicester City CCG.

Note: The meeting was not open to the public in line with Government advice on public gatherings however the meeting was broadcast live via YouTube.

41. Minutes of the previous meeting.

The minutes of the meeting held on 13 January 2021 were taken as read, confirmed and signed.

42. Question Time.

The Chief Executive reported that no questions had been received under Standing Order 35.

43. Questions asked by members..

The Chief Executive reported that no questions had been received under Standing Order 7(3) and 7(5).

44. Urgent items.

There were no urgent items for consideration.

45. Declarations of interest.

The Chairman invited members who wished to do so to declare any interest in respect of items on the agenda for the meeting.

No declarations were made.

46. Declarations of the Party Whip.

There were no declarations of the party whip in accordance with Overview and Scrutiny Procedure Rule 16.

47. Presentation of Petitions.

The Chief Executive reported that no petitions had been received under Standing Order 35.

48. Recommissioning of Domestic and Sexual Violence and Abuse Services.

The Committee considered a report of the Director of Public Health which informed of the plans for the recommissioning of the domestic and sexual violence and abuse services (DSVA) and the proposed model for DSVA. A copy of the report, marked 'Agenda Item 8', is filed with these minutes.

The Chairman welcomed Mr. L. Breckon JP CC, Cabinet Lead Member for Health, Wellbeing and Sport, to the meeting for this and other items.

Arising from discussions the following points were noted:

(i) Responsibility for commissioning DSVA had recently transferred from the Children and Family Services department within the County Council to the Public Health Department which was why the Health Overview and Scrutiny Committee had not had the opportunity to scrutinise the service previously.

(ii) Domestic and sexual violence and abuse services in Leicester, Leicestershire and Rutland currently comprised the United Against Violence and Abuse (UAVA) service which was delivered by a consortium comprising Women's Aid Leicestershire Ltd (WALL), Free From Violence and Abuse (Freeva), and Living Without Abuse (LWA). In response to a question about the efficiency of having 3 separate organisations delivering the DSVA service it was explained that as commissioners Public Health were not in control of which organisations submitted a bid and could not pre-judge which organisation would win the contract. Members asked for a flow diagram which demonstrated how all the partner organisations linked in together on Domestic Abuse and what proportion of the funding each received and the Director of Public Health agreed to provide this.

(iii) The specifications of the DSVA service stated that it was required to meet the needs of all victims which would include males as well as females.

(iv) There were concerns that the current service was very output focused when it was preferable for it to be more outcomes focused with the emphasis on improving the health and wellbeing of the people of Leicestershire rather than meeting Key Performance Indicators. The Director did not want to be too prescriptive with the way the new services were carried out. Moving the service to a more local model for Leicestershire would mean that local need could be better taken into account for example in rural areas and local contract performance monitoring could take place. It was suggested that future performance reports to the Committee could contain the performance data relating to domestic and sexual violence and abuse services.

(v) Leicester City Council was leading on procurement of Domestic violence and abuse Perpetrator Interventions. However, Leicestershire County Council was aware that the majority of perpetrator programmes were focused on those perpetrators that wanted to change their behaviours whereas the County Council preferred to invest in a programme that would work with all perpetrators whether they wished to change their behaviour or not. The County Council was carrying out further work in this regard and in the meantime it was intended that Leicestershire County Council would spot purchase the Perpetrator Interventions service. Aside from the local authority led perpetrator work there was other work taking place with perpetrators across the criminal justice system.

(vi) The Government had provided additional funding to local authorities to provide safe accommodation for abuse survivors and their families, and Leicestershire had received £1.1 million from this fund. Consideration was being given to where this money should be spent and the governance arrangements around it. It was hoped that the funding would not just provide a refuge for victims but help put in place wider initiatives for keeping survivors safe.

(vii) Commissioning partners did liaise and engage with Community Safety Partnerships particularly during development of the draft proposal. Also a representative from Public Health attended Leicestershire Safer Communities Strategy Board meetings.

(viii) Consideration was being given to whether the Health Overview and Scrutiny Committee could, jointly with other scrutiny Committees carry out a wider piece of scrutiny work related to what initiatives the County Council had in place to protect women from violence and harm.

RESOLVED:

(a) That the update regarding the recommissioning of the domestic and sexual violence and abuse services (DSVA) and the proposed model for DSVA be noted;

(b) That the comments now made be submitted to the Cabinet for consideration at its meeting on 23 March 2021.

49. Health Performance and LLR Health System Governance and Design Group Update.

The Committee considered a joint report of the Chief Executive and the CCG Performance Service which provided an update on public health and Clinical Commissioning Group (CCG) performance in Leicestershire and Rutland based on the available data at the end of February 2021. The report also outlined the latest position on Leicester, Leicestershire and Rutland (LLR) Health System Governance, Structure and Design Group Formation. A copy of the report, marked 'Agenda Item 9', is filed with these minutes.

The Committee welcomed to the meeting for this item Kate Allardyce Senior Performance Manager, NHS Midlands and Lancashire Commissioning Support Unit and Hannah Hutchinson, Assistant Director of Performance Improvement, Leicester City CCG.

Hannah Hutchinson gave a presentation regarding the Design Groups and system governance in Leicester, Leicestershire and Rutland. A copy of the presentation slides is filed with these minutes.

Arising from discussions the following points were noted:

Design Groups and System Governance

(i) The Design Groups were part of the move towards an Integrated Care System (ICS) in LLR and a shadow ICS was to be in place from April 2021. The model would include three levels: System, Place and Neighbourhood. It was noted that the Neighbourhood level would comprise of areas with a population of 30,000 to 50,000 people but a member questioned whether that was too large an area to be described as a Neighbourhood and suggested most people consider their neighbourhood to be a much smaller area. Members welcomed the plans for the new system and supported the aims.

(ii) In response to a question from a member regarding where the Health Overview and Scrutiny Committee fitted into the governance structure it was agreed that further consideration would be given to this by the CCGs and a new diagram circulated.

(iii) It needed to be ensured that each Primary Care Network had access to equipment such as electrocardiogram machines so that patients could undergo non-urgent procedures locally and that hospitals were reserved for patients with acute needs. Further work was being undertaken by the CCGs in this regard.

(iv) There were a number of different ways the CCGs interacted with patients and the public including through Healthwatch and Patient Participation Groups and it was intended that once the ICS was in place meaningful conversations with patients would still take place. The CCGs offered to provide further details regarding public engagement to the Board after the meeting.

Public Health and CCG Performance

(v) Since the performance report had been published cases of Covid-19 had reduced by 9% across Leicestershire. On 5 March 2021 the LLR SAGE Committee had downgraded the alert level from level 5 to level 4 and University Hospitals of Leicester NHS Trust had also set their alert level to 4.

(vi) When the Covid-19 pandemic first began there had been a reduction in cancer referrals compared to the previous year however this reduction did not continue and referrals subsequently increased to a similar level to the previous year. As a result of the pandemic some cancer procedures were being carried out by private hospitals on behalf of the NHS. NHS England had asked CCGs to continue the contracts with the independent sector into the 2021/22 financial year as there was still work to do to catch up on the backlog. Whilst awaiting procedures the patients were being clinically reviewed and prioritised.

(vii) Due to the nature of the ‘one year survival from all cancers’ metric the data took a long time to be reported. It was expected that the next set of data for that metric would be available in May 2021.

(viii) With regards to the Improving Access to Psychological Therapies metric it was noted that extra training places for high intensity workers were being made available. In response to questions from a member it was agreed that further details and clarification regarding this would be provided to members after the meeting.

(ix) Appendix 2: The CCG Performance Dashboard did not contain any data for the metric 'Proportion of People with a learning disability on the GP register receiving an annual health check' because Appendix 2 had been taken from NHS England's national data source. However, locally the CCGs received data on a weekly basis regarding the proportion of people with learning disabilities receiving health checks.

(x) It was noted that the percentage of adults classified as overweight or obese was high yet the percentage of physically active adults was also high and it was therefore questioned whether these two data sets were contradictory. The Director of Public Health stated he would give this issue further consideration but emphasised that diet also played a part in people's weight. It was noted that the time period for both sets of data was 2018-19 therefore the Covid-19 pandemic and lockdown could not have impacted on the data.

(xi) The data for 'Breastfeeding prevalence at 6-8 weeks after birth' was available but could not be published due to data quality issues. The data for 'HIV late diagnosis' was also available but could not be published because the numbers were so small that individuals could potentially be identified from the data.

(xii) Members asked that future performance reports contain a glossary of commonly used phrases and acronyms in relation to the health and care system. It was also requested that when data was provided more information be provided to explain the context for example how Leicestershire compared to the rest of the country. It was suggested that the performance reports that were submitted to CCG Board meetings could also be forwarded to the Health Overview and Scrutiny Committee, though as they covered the whole of LLR the data would not be broken down into Leicestershire.

RESOLVED:

(a) That the update regarding the Leicester, Leicestershire and Rutland Health System Governance, Structure and Design Group Formation be welcomed;

(b) That the performance summary and issues identified be noted.

50. Date of next meeting.

RESOLVED:

It was noted that the next meeting of the Committee would be held on Wednesday 2 June 2021 at 2.00pm.

2.00 - 3.45 pm
18 March 2021

CHAIRMAN

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HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 2 JUNE 2021

REPORT OF HEALTHWATCH LEICESTERSHIRE

EX HM ARMED FORCES: SPOTLIGHT ON MENTAL HEALTH SERVICES

Purpose of report

1. This report gives a summary of the findings gathered by Healthwatch Leicester and Healthwatch Leicestershire in relation to the experiences of people who have served in Her Majesty's (HM) Armed Forces and their experience of Mental Health Services in Leicester and Leicestershire.

Background

2. The County Council, following the Health and Social Care Act 2012, is required to directly commission a local Healthwatch. The local Healthwatch in turn has a set of statutory activities to undertake, such as gathering local views and making these known to providers and commissioners, monitoring and scrutinising the quality of provision of local services and a seat on the Health and Wellbeing Board.

3. The purpose of Healthwatch Leicestershire (HWL) is to promote improvements in local health and social care services – improving outcomes for local people in Leicestershire. HWL believes that the best way to do this is by designing local services around the needs and experiences of local people.

4. Through patient and public engagement Healthwatch became aware of the different patient experience in relation to medicine prescription, when issued from an acute hospital or when issued from their GP practice, when part of an overall treatment experience.

Contents of the report

5. The report shares the findings regarding where ex HM Armed Forces personnel go for support, if the support helped them or not, and what they think can be changed to improve services.

Officer to Contact

Mukesh Barot - Chief Officer
Healthwatch Leicester and Healthwatch Leicestershire
Tel: 0116 2518313|
email:Mukesh.Barot@healthwatchLL.com

List of Appendices

EX HM Armed Forces: Spotlight on Mental Health Services report

Relevant Impact Assessments

Equality and Human Rights Implications

6. HWL is aware that the Public Sector Equality Duty (PSED) applies to all functions of public authorities that are listed in Schedule 19 Equality Act 2010. Schedule 19 list does not include Healthwatch England or Local Healthwatch organisations, however as bodies carrying out a public function using public funding we are subject to the PSED general duty.

7. ECS/ Healthwatch Leicestershire is committed to reducing the inequalities of health and social care outcomes experienced in some communities. We believe also that health and social care should be based on a human rights platform. We will utilise the Equality Act 2010 when carrying out our work and in influencing change in service commissioning and delivery.

APPENDIX

healthwatch Leicester healthwatch Leicestershire

EX HM Armed Forces: Spotlight on Mental Health Services

May 2021

Introduction

Healthwatch Leicester and Healthwatch Leicestershire (HWLL) are the local independent voice of the public in the delivery of Health and Social Care in Leicester and Leicestershire. We collect feedback from members of the public about their experiences of using health and social care services. One of the ways that feedback is collected is through our special projects based on the experiences shared by the public and conversations with the local authorities.

Background

This project focused specifically on the experiences of people who have served in Her Majesty's (HM) Armed Forces and their experience of Mental Health Services in Leicester and Leicestershire. We wanted to find out where ex HM Armed Forces personnel went for support and if it helped them or not, as well as understand who has supported them most and what they think can be changed to improve services.

The Armed Forces Covenant is a focus for many strategic partners who provide support for people who have served in HM Armed Forces. The covenant is a pledge to those who serve or have served in HM Armed Forces, that they and their families are treated with fairness and respect in the communities they have served.

What We Did

A survey was created to consult people who had served in HM Armed Forces so that they could share their experiences anonymously. All those who completed the survey identified as having experiences of using mental health services. The survey was made available to people online due to the Covid-19 pandemic. We used social media to reach people to whom the survey would be relevant, as well as communicating with people from relevant voluntary organisations.

An initial online event was held to talk about the project, and we spoke to voluntary and strategic partners working with people who have served in HM Armed forces. We discussed creating a Veterans Forum and the first forum was held with the hope that if there was interest, this would be a long-term initiative.

The people who attended the forum were from strategic and voluntary sectors and we discussed the question of duplication as there are other forums already established.
It was therefore decided that HWLL would not continue with a forum of its own but would attend the Civil and Military Partnership Board and support initiatives that way.

Key Findings

28 people responded to the survey. Please note that not all questions were answered by all respondents.

10 people (36%) said they started to have mental health issues whilst serving in the Armed Forces and 18 (64%) said it was when they left the service. Only 3 people (11%) had tried to access support through the Armed Forces.

13 people (50%) said they live with more than one mental health condition with anxiety, depression and post-traumatic stress disorder (PTSD) being the most common. This reflects the complexity of mental health issues amongst people who have served in HM Armed Forces.

GP registration was high, with 26 people (92.8%) saying they are registered with a GP 21 people (81%) said they have told their GP they served in HM Armed Forces. One person said they "didn't know it made a difference" and another that "it's never come up".

Nine people (32%) haven't looked for support. The reasons given for this included the stigma and embarrassment of asking for support as well as a concern they wouldn't be understood. 19 people (68%) have looked for support. Of those 19 people, 42% have looked in more than one place.

When asked how helpful the support they received had been, 9 people (50%) said it had helped. This included 3 people who had private counselling, people who had received a mixture of support from their GP and Voluntary Organisations, and one person who had received support solely from the Armed Forces. Nine people said the support they had received had not been helpful. These people had tried to find support through their GP and voluntary organisations.

Respondents who had needed to access urgent mental health services were asked how easy they found this. Six people (60%) said it was average to very good with 4 people (40%) advising it was poor or very poor.

15 (54%) people said they would not feel comfortable accessing civilian services or being referred to them. The main reason given was that they didn't feel a mainstream service would understand the issues they face.

Nonetheless, 7 people (25%) said they felt excluded from mainstream services. The reasons given were that people were treated as civilians without understanding of the Armed Forces Covenant, offered inappropriate group therapy or that waiting times were too long.

When asked who had helped them the most, 8 people (30%) said it was their wife or partner. Other veterans and family were also identified as source of support by 5 people (19%).

We asked for suggestions about ways to improve experiences. A focus on specific services was often mentioned. Peer support was another theme as well as improvements in signposting and the importance of a consistent service being provided.

All about Veterans – Survey Findings

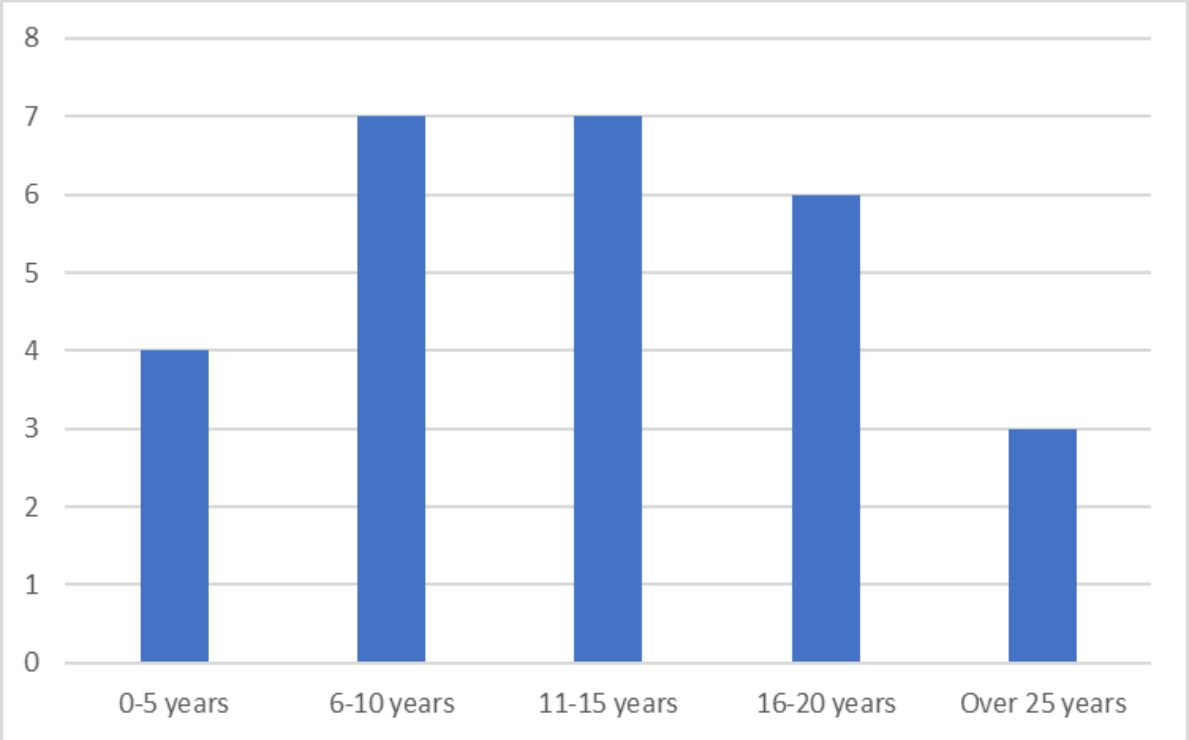
The following issues were captured by the survey.

Parts of the Armed Forces respondents had served in:

Royal Navy	0
Royal Marines	2
British Army	22
Royal Air Force	5
Reserves	2
Merchant Mariners	0

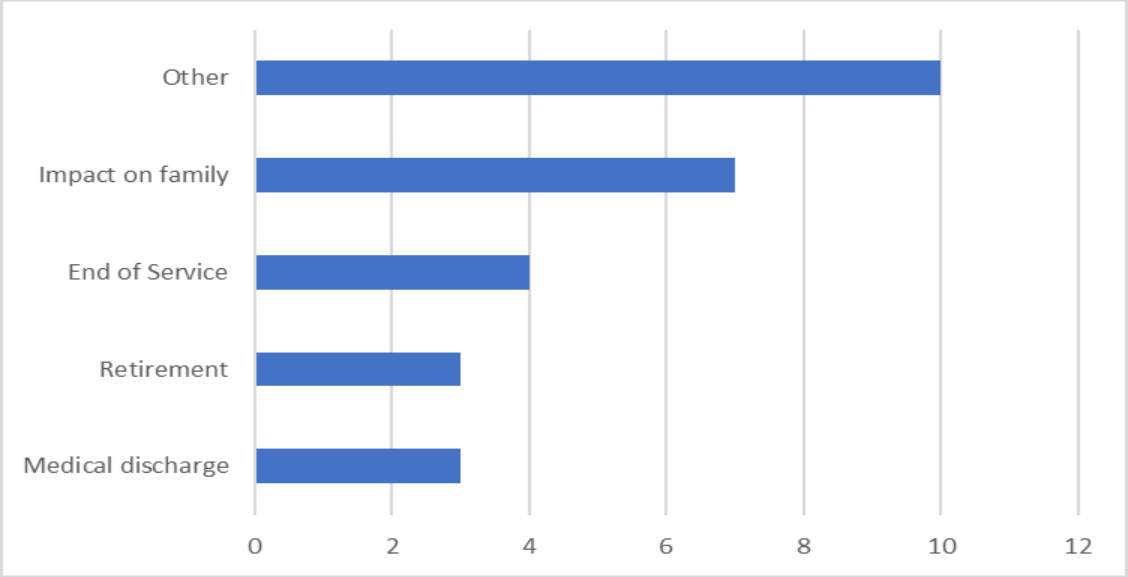
3 people had served in 2 different branches.

Length of service



1 person did not answer this question.

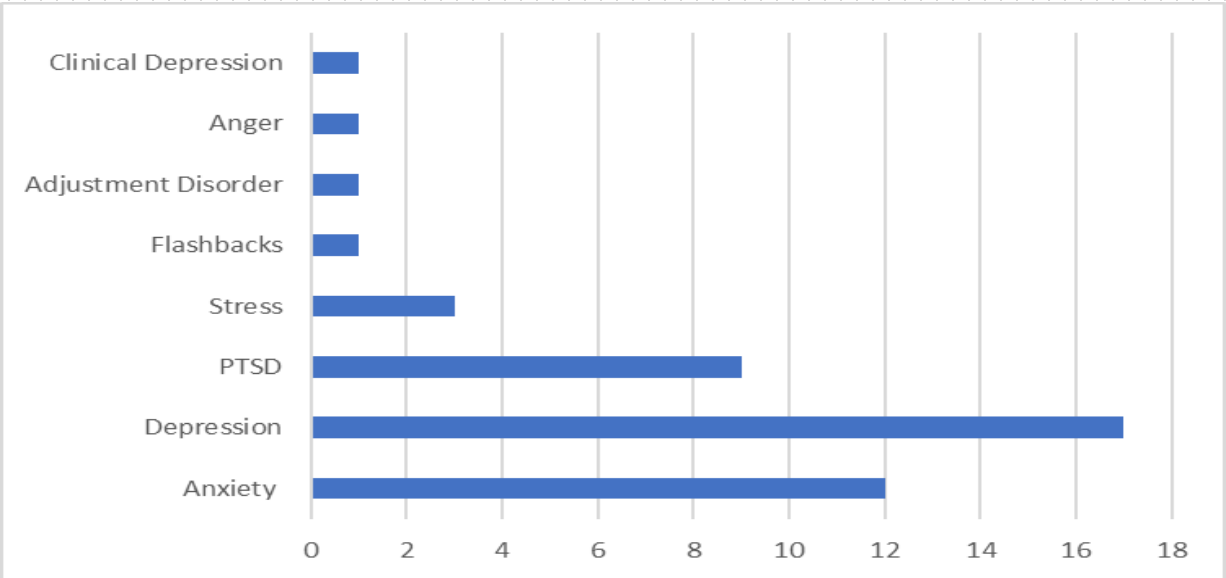
Reasons for leaving



1 person did not answer this question. Under "other" the only common theme was redundancy with 3 people stating this is why they left HM Armed Forces. All other reasons were individual to the people responding. 1 person said they left because of mental health reasons.

We asked respondents when they started to suffer from mental health issues.

10 people (36%) said they started to have mental health issues whilst serving and *18 (64%)* said it was when they left the service. The kind of mental health issues they faced included:



26 people answered this question in their own words. *13 people (50%)* said they live with more than one mental health problem with anxiety, depression and PTSD being the most common.

We asked if people were registered with a GP and *26 (92.8%)* people said they are registered with a GP and 2 said they are not. Of the 26 people who are registered with a GP 21 people (81%) have told their GP that they are HM Armed Forces Service Leavers. *5 people (19%)* said they haven't told their GP.

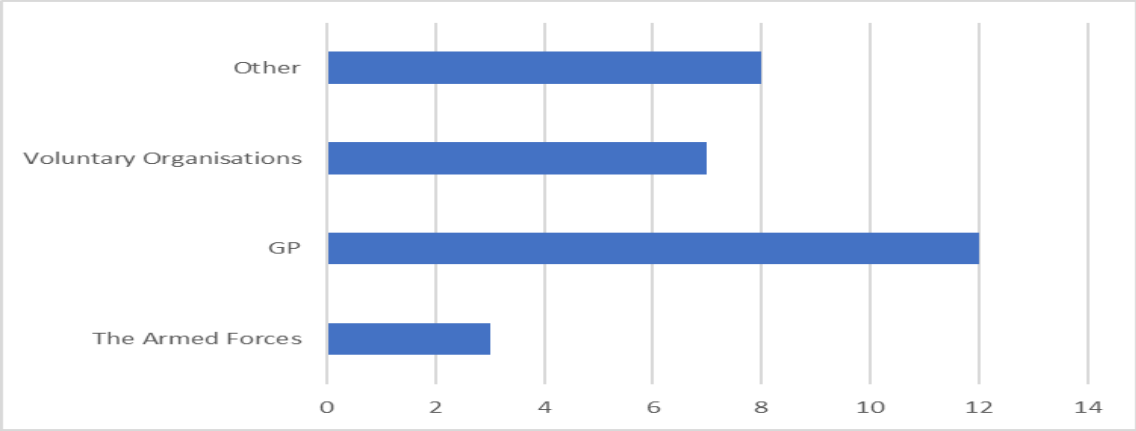
When asked why they haven't advised their GP 4 people responded:

- Did not know that it made a difference
- Changed GP and no longer suffer
- It never came up
- I've never really told this GP about my issues, I told an old GP years ago

When asked if they had tried to find support for the mental health issues experienced *19 people (68%)* said they had looked for support. *9 people (32%)* said they have not. The people who haven't gave a variety of reasons.

- Only charities
- Stigma and lack of time
- Too proud and embarrassed I guess
- I'm not sure of a genuine reason
- Not confident support will be there or that I would be understood
- I rely on support from other veterans

Where have you found support:



9 people (42%) have sought support from more than place. *12 people (63%)* went to their GP.

Including the voluntary organisation specified in "other" *7 people (37%)* as places they have tried to find support.

Respondents were asked if they felt that the support provided helped

9 people (50%) said it had helped including all 3 people who had private counselling and people who had received a mixture of support from their GP and Voluntary Organisations. 1 person who had received support solely from the Armed Forces said this had helped, but *9 others (50%)* said the support they looked for had not helped.

Support respondents received (sic):

- 'Combat Stress' although very stretched helped a lot as did my GP
- The support was limited to available resource and is clearly under funded
- Royal Navy Benevolent Fund managed to find me a counsellor very quickly to start therapy
- It helped Yes & No I am on medication, but never really spoken to anyone about it
- I paid for a private counsellor as the NHS 'Let's talk' wellbeing took too long (8 months)
- Sadly due to disjointed non continuous way the counselling worked out the progress made was undone
- 'Mind' helped a little but the wait lists were so long I started to feel better myself
- 'Combat Stress' helped me with mental health training, education and treatment
- The counsellor had no experience of the military and just couldn't support me
- I only got seen twice and they said once I got a new job, I would be okay

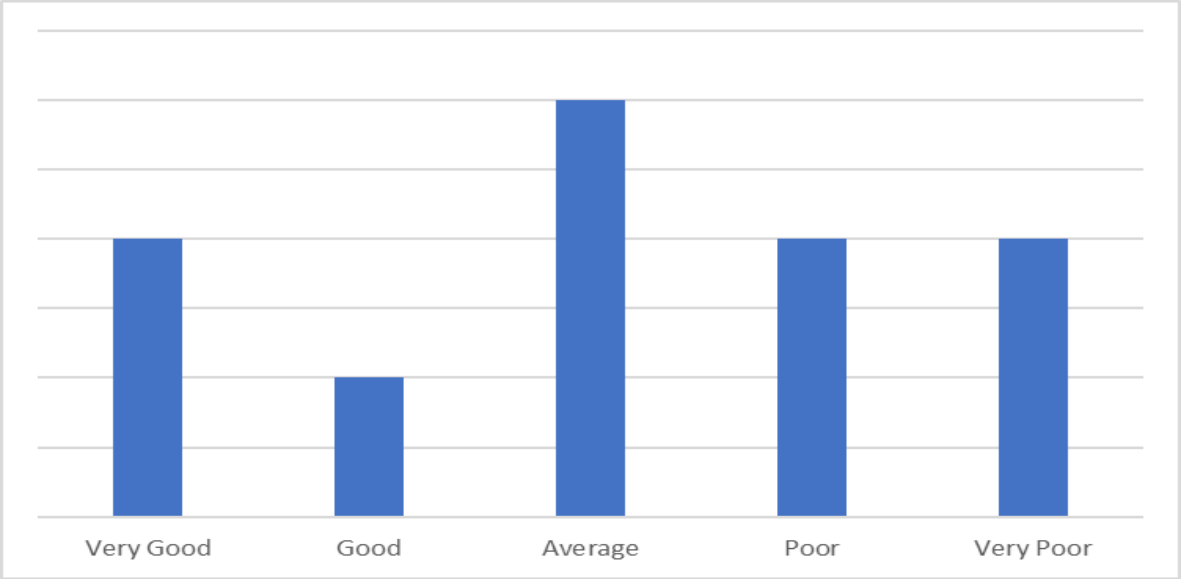
Common themes include the importance of continuous and timely support as well as funding.

Urgent or immediate Mental Health care

17 people (63%) said they hadn't required urgent or immediate mental health care

10 people (37%) said they had.

The table below rates how easy it was for people who required immediate or urgent to access urgent Mental Health Services.



6 people (60%) said it was average to very good with *4 people (40%)* advising it was poor or very poor.

Respondents were asked if they would be comfortable accessing or being referred to non-veteran specific services.

13 people (46%) said they would be comfortable, *15 people (54%)* said they wouldn't be.

The reasons given for not feeling comfortable included:

- Meddling
- I do not feel that anyone who has not served/ been associated with the Armed Forces really understands
- Quite simply, a civilian organisation has zero knowledge of service life
- Feel they wouldn't understand
- too proud and embarrassed I guess

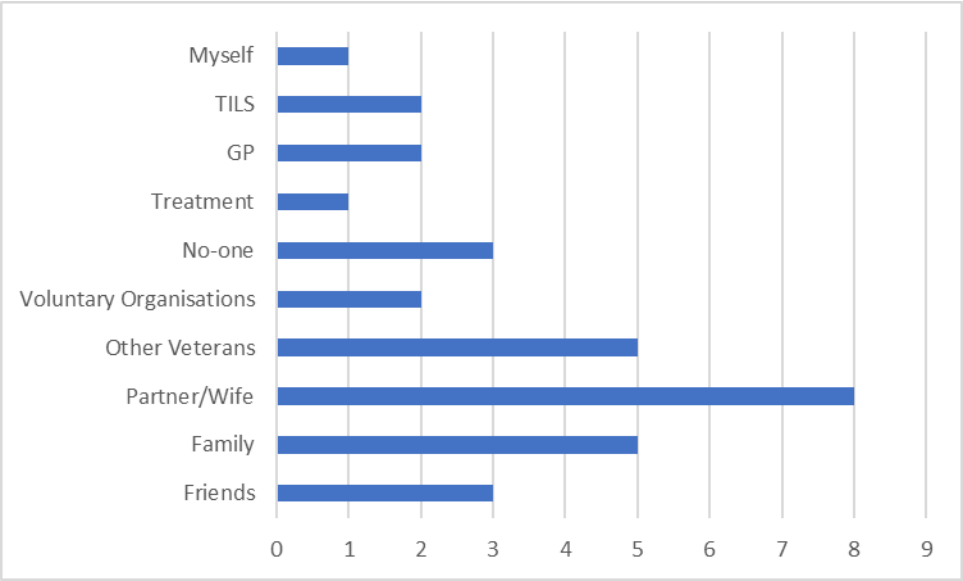
- if it was a quicker service, you are left waiting too long for help
- Must understand service life
- have done it previously
- I'd rather speak to active service personnel who (I believe) would understand my issues better
- Non-veteran services don't understand my issues and how they affect me.
- Because they do not understand what I went through
- Previous experience
- It would be better to talk to people who have been through the same experience that I went through.

Mainstream services

21 people (75%) said they did not feel excluded from mainstream services, *7 people (25%)* said they did.

- Many NHS organisations do not know about the AF Covenant and treat you as a civilian
- Went for counselling but it was group therapy - my circumstances were so different
- Waiting times are too long
- Because they cannot provide the support, I require
- Lack of understanding
- As a reservist felt let down by Army then passed pillar to post

Mental Health Support



For this question, people could give multiple responses. A partner or wife was the mentioned the most when asked who had supported them, with family and other veterans also being prominent.

Respondents shared what could have been done differently to improve the support they received:

- Use Veterans and Armed Forces charities more
- Provide effective and accessible support using veteran healthcare professionals
- Providing more information as to the services available in the civilian sector
- Access to Mental Health Counsellor Therapist needs be quicker, waiting 5 to 7 months is bad
- Been honest with myself earlier
- Better information but in recent years I feel this has got a lot better
- The East Midlands need to be quicker and signpost veterans to suitable charity or local assistance
- I should have talked to someone
- Time delays & more targeted approach
- To have a dedicated (Service based) support group
- being more accessible
- Need someone who understands the dark humour used as a coping mechanism

- **Shorter wait list more targeted support and support for my family**
- **Seeing the same doctor every time that understands about mental health**
- **Having access to a specific' veteran-aware' service**
- **Recognise veterans are a special case**
- **That supporters understand issues specifically affecting veterans**
- **Seeing a military counsellor**
- **A bit more financial support**
- **To be seen more times about my mind state**

Conclusions

- Results highlight the complexity of mental health issues experienced by ex-service personnel: ***50%*** of people said they live with more than one mental health condition.

- A large proportion are registered with a GP ***(92.8%)***, which is encouraged when leaving the service. This seems to be working as ***81%*** of those registered with a GP have told their GP that they served in HM Armed Forces.

- There is room for improvement in the take up of mental health support: ***32%*** of respondents have chosen not to seek support.

- Satisfaction with metal health services was not high: only 50% of people who had accessed the services found them helpful. Some people reported long waiting times and stretched or under-funded services.

- Just over half the people who responded felt uncomfortable accessing mainstream mental health services. More specialist agencies such as Combat Stress were praised by those who had used them. A lot of the comments we received mentioned the importance of talking to somebody who had military experience.

- The support of wives / partners is incredibly important, along with other informal support from family and other service leavers.

Recommendations

1. The Armed Forces Covenant should be advertised in public areas such as GP waiting rooms to raise awareness that telling your GP makes a difference. As standard across GP practices the question should be asked “Have you served in HM Armed Forces?” when registering.
2. Specific services for those that have served in HM Armed Forces should also be signposted in public areas of Health and Social Care services.
3. For those who don’t want a specific ex-military service, better signposting of mainstream services could help them to access support more quickly and efficiently, so they don’t have to reach out to more than one organisation.
4. Opportunities should be created to reinforce the message of the Armed Forces Covenant when training NHS professionals, so that provision is adjusted to meet people’s specific needs.
5. Support for partners and family members should be considered in recognition of the role that they play in helping their loved ones.

Next steps

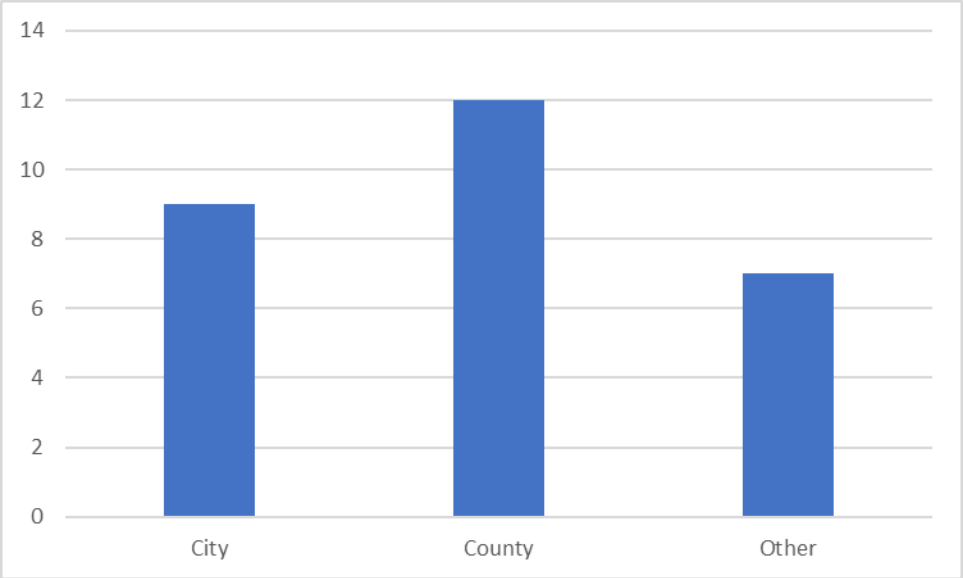
This report begins a conversation between service users, commissioners and providers. It provides a platform for commissioners to act on user experiences and recommendations to improve processes. Providers have the opportunity to review how best to deliver services in the future.

We will share this report with our wider health and social care stakeholders and continue to gather evidence and insights from service users, the public and patients to champion their voice at every opportunity.

Appendix A - Demographic Information

All demographic information that was completed is captured below. Some participants chose not to complete this section or only completed parts of it.

What is the first part of your postcode?



7 respondents now live-in different parts of the country. As the survey and any social media made clear reference to Mental Health Services in Leicester & Leicestershire, we have still included this information.

What age group are you in?

25 – 34 years	2
35 – 44 years	5
45 – 54 years	6
55-64 years	13
65 or over	2

What ethnic background do you identify as?

White British/English/Scottish/Welsh/Northern Irish – 28

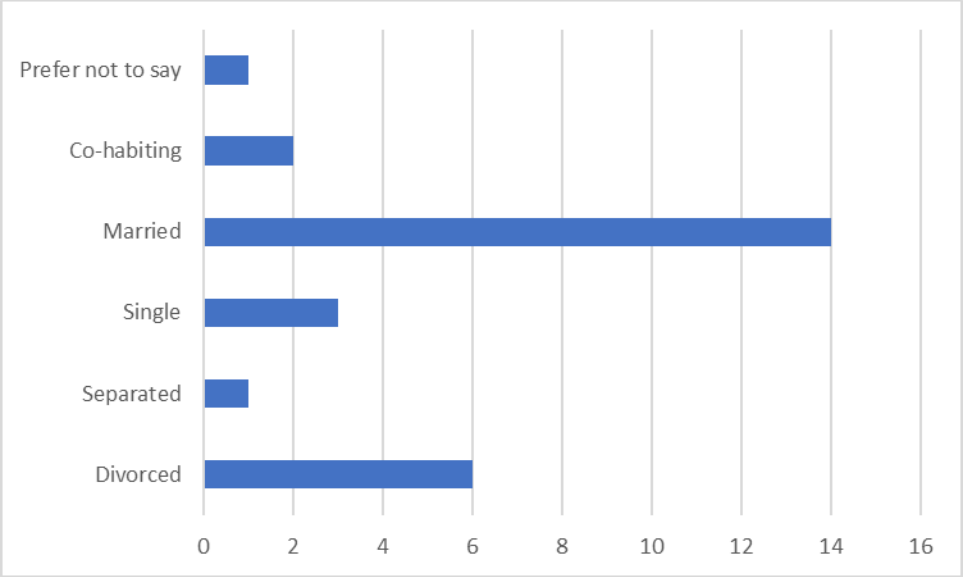
Mixed White and Asian – 1

Most respondents identified as White British/English/Scottish/Welsh/Northern Irish. If Healthwatch does more work with people who have served in HM Armed Forces in the future, we should look at how we involve people from the BAME community.

What is your religion or belief?

Christian	16
No Religion	7
Prefer Not to Say	2

What is your marital status?



What is your sexual orientation?

26 people identified as heterosexual. Two people preferred not to say.

Do you consider yourself to have a disability or long-term condition?

No	13
Yes	15

healthwatch

Healthwatch Leicester
and Healthwatch
Leicestershire, Clarence
House, 46 Humberstone
Gate, Leicester, LE1 3PJ

www.healthwatchll.com
0116 2518313
enquiries@healthwatchll.com
tw: @HealthwatchLeic
FB: @HealthwatchLL
Instagram: HealthwatchLeic

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Leicestershire County Council

HEALTH OVERVIEW AND SCRUTINY COMMITTEE – 2nd June 2021

SUICIDE PREVENTION

REPORT OF THE DIRECTOR OF PUBIC HEALTH

Purpose of the Report

1. This report is to provide an update on developments in Suicide Prevention from Public Health and its partnership group, the LLR Suicide Audit and Prevention Group (SAPG). This report provides an overview of the current data and actions taken to address and prevent suicide within Leicestershire.

Policy Framework and Previous Decisions

2. Suicide Prevention links closely with the strategic outcome of 'Well Being and Opportunity' which forms part of the Council's Strategic Plan.

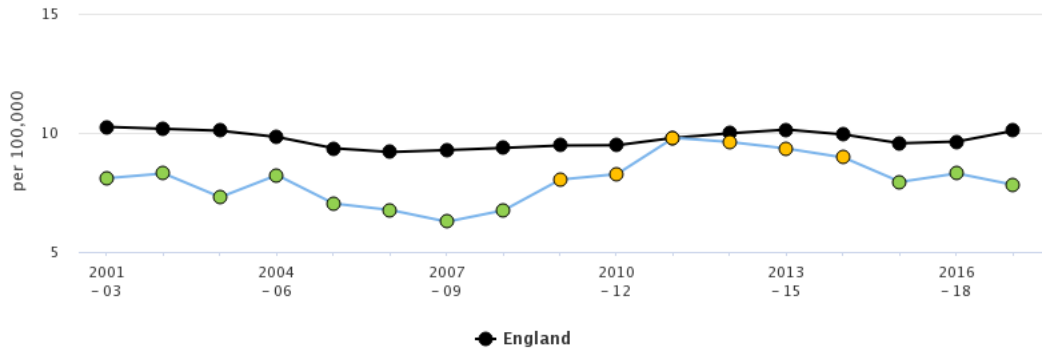
3. In 2018, Public Health were tasked, by the leader of the council, to provide a more public facing approach to suicide prevention. This resulted in the development of the Start a Conversation campaign: https://www.startaconversation.co.uk/

Background

4. In 2020 the LLR Strategic Approach to Suicide Prevention, developed by the SAPG, was agreed. The approach concentrates on key messages including that suicide is everyone's business and focuses on 9 key priorities including; high-risk groups, supporting primary care and protecting people with a history of self-harm.

Issues

5. The graph below is taken from Public Health England (PHE) 'Fingertips' and highlights the trends of Leicestershire compared to England from 2001/03 – 2017/19 with regards to suicide rates. This graph captures all recorded suicides. The County directly standardised rate (DSR) for 2017-19 (7.8 per 100,000), was lower than the national average (10.1 per 100,000), there were 144 county deaths during this time.



6. Real Time surveillance data (RTSD), provided by Leicestershire Police showed a peak in suicides in Leicestershire residents in 2018. The number of suicides in Leicestershire decreased in 2019, but in 2020 increased to a similar level to 2018.

   N.B. RTSD is data collected around a death which may be due to suicide but before a coroners decision has been made. The RTS data enables support to be given around high risk individuals, in a timely way to help prevent further harm.

7. RTSD suggests that there have been higher than usual numbers of student suicides (RTS data) recorded in LLR in the past 12 months. Further work is being done to understand these deaths, to put in place support for those affected, and to assess robustness of the data.

8. The Impact of COVID-19 on suicides - Whilst the RTSD suggests that there may have been a slight increase in numbers of suicides in Leicestershire residents in 2020 compared to the previous year (though similar to 2018)it is too soon to say if there has been a significant impact due to COVID.

9. National [1] and international [2] studies to date, have not found a significant rise in the risk of suicide since the pandemic began.

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[1] https://www.thelancet.com/journals/lanepe/article/PIIS2666-7762(21)00087-9/fulltext
[2] https://www.thelancet.com/action/showPdf?pii=S2215-0366%2821%2900091-2.

However, it is important to note that these are early figures and there may be increases in suicides in some populations or geographical areas.

10. The 'high-risk' groups in Leicestershire include middle aged men, those in the care of mental health services and those with a history of attempted suicide/self-harm. Source: RTSD.

Response to COVID-19

11. Weekly SAPG meetings were initiated to ensure clear communication between all partners, and suicides were captured on a weekly basis via the RTS data. This allows for rapid response to noticeable trends. A group has been established to map and focus on student suicides as per the rise noted above.

12. Working with Leicestershire Provider Trust, the City Council and the Police, suicide mental health resources and communication plans were developed, both for adults and for children and young people. The online resources are accessed by approximately 1,000 people per month via the Start a Conversation website and social media campaign.

Reducing Suicides

13. Several programmes have been developed to reduce suicides across Leicestershire:

- **The Tomorrow Project** (Suicide Bereavement) continues to provide post intervention support to those bereaved by suicide, which, in itself, is a risk factor for suicide.

- A **Community Self-Harm Programme** is being developed utilising the 'Contain Funding' to address self harm. This is an LLR programme led by Public Health, LCC. This will focus on both lower level prevention and early intervention work, as well a community-level service to support individuals who self-harm, which is a risk-factor of suicidality. This is supported by the CCG and the wider SAPG.

- **Men's Mental Health Peer-Support Groups** are currently being procured. Men in middle-age are at greatest risk of suicide. Evidence shows that early intervention in the community, alongside other men, can reduce suicide risk.

- A successful funding bid to the CCG has seen the development of **GP and Primary Care Suicide Mitigation** training to improve

clinical confidence and competence around suicide prevention. By March 2021, 60 clinicians will have undergone the training.

- The Rural Community Council are contracted to provide **Suicide Awareness and Self Harm Training**. For 2021, 8 suicide Awareness Sessions and 4 Self-Harm sessions will be delivered. Some specifically aimed at schools to tackle the anecdotal rises of self-harm which have been highlighted.

- **Self-Harm Mobile App** (DistrACT) has been procured to provide an alternative source of support.

14. The Start a Conversation Campaign continues to be successfully delivered and promoted throughout LLR:

    - The website serves as key resource for the public and professionals to access high-quality resources and signposting to services.

    - Since March 2020 the Covid-19 and Mental Wellbeing Page has received just under 5000 unique visits.

    - The second annual Suicide Prevention Conference was held virtually in September 2020, delivered by Public Health. The conference saw 16 events, spread over 5 days and was attended by over 450 individuals. A further event is planned for 2021.

Wave 4 Suicide Prevention

15. Through the NHS Long Term Plan, NHS England and NHS Improvement (NHSE/I) have committed to expand the Suicide Prevention Programme (previously piloted in other parts of the country, not including East Midlands) to all areas of the country. Working together with the CCG and Leicester City Council, we were successful in a Wave 4 bid to reduce suicide's across LLR.

16. A Suicide Prevention Project Officer will be recruited to oversee the development and the delivery of the project, which will focus on place and neighbourhood-based community mental health improvement work, to contribute to reducing suicides.

Conclusion

17. The impact of COVID-19: Whilst the RTS data we have to date appears to show an increase in suicides from 2019 to 2020, these numbers should be viewed with caution as this data may be incomplete, and has not yet been subject to the coronial process. Also

suicides tend to vary year by year e.g. numbers of suicides (RTSD) recorded in 2018 were similar to those in 2020.

18. A number of services and campaigns have been put in place with the aim of reducing suicides, supporting those who self-harm and providing services to those bereaved by suicides.

19. Work will continue to be developed, under the umbrella of the LLR Suicide Audit and Prevention Group.

Background Papers

20. None.

Circulation under the Local Issues Alert Procedure

21. None.

Officers to Contact

Fiona Grant
Consultant in Public Health
T: 0116 305 7929
E: Fiona.grant@leics.gov.uk

Hollie Hutchinson
Health Improvement Manager
T: 0116 305 4204
E: hollie.hutchinson@leics.gov.uk

List of Appendices

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