Notice of a public meeting of
Health, Housing and Adult Social Care Policy and Scrutiny Committee

To: Councillors Doughty (Chair), Cullwick (Vice-Chair), Cuthbertson, Flinders, Richardson, K Taylor and Warters

Date: Wednesday, 14 November 2018

Time: 5.30 pm

Venue: The George Hudson Board Room - 1st Floor West Offices (F045)

A G E N D A

1. Declarations of Interest (Pages 1 - 2)
At this point in the meeting, Members are asked to declare:

- any personal interests not included on the Register of Interests
- any prejudicial interests or
- any disclosable pecuniary interests

which they may have in respect of business on this agenda.

2. Minutes (Pages 3 - 8)
To approve and sign the minutes of the meeting held on 16 October 2018.

3. Public Participation
At this point in the meeting, members of the public who have registered their wish to speak regarding an item on the agenda or an issue within the Committee's remit can do so. The deadline for registering is **5:00 pm on Tuesday 13 November 2018.**

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The Council's protocol on Webcasting, Filming & Recording of Meetings ensures that these practices are carried out in a manner both respectful to the conduct of the meeting and all those present. It can be viewed at: http://www.york.gov.uk/download/downloads/id/11406/protocol_for_webcasting_filming_and_recording_of_council_meetings_20160809.pdf

4. Mental Health Support Line (MHSL) Review and Refresh (Pages 9 - 14)

This report updates the committee on the Mental Health Support Line services offered in York, as requested by this committee.

5. Home First Engagement - Initial Feedback Report (Pages 15 - 22)

This report provides a summary of the initial findings from an engagement exercise with local people about Home First.

6. Healthwatch York: Performance Monitoring / Six Monthly Review (Pages 23 - 40)

This report provides the Committee with the bi-annual performance monitoring report for Healthwatch York.

7. Suicide Prevention and Self-harm Overview Report (Pages 41 - 142)

This report provides a summary of progress and recent activity in relation to suicide prevention and self-harm, as requested by the Health, Housing and Adult Social Care Policy and Scrutiny Committee.

8. Update on Oral Health in the City of York (Pages 143 - 148)
This report outlines the aims of the Oral Health Improvement Advisory Group (OHIAG) that has been established to look into the reasons for York's high numbers of hospital admissions for dental care in Children and to update the committee of the work undertaken by the group so far.

9. Work Plan (Pages 149 - 152)
Members are asked to consider the Committee's work plan for the municipal year.

10. Urgent Business
Any other business which the Chair considers urgent.

Democracy Officer:

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For more information about any of the following please contact the Democracy Officer responsible for servicing this meeting

- Registering to speak
- Business of the meeting
- Any special arrangements
- Copies of reports

Contact details are set out above

This information can be provided in your own language.

我們也用您們的語言提供這個信息 **(Cantonese)**

এই তথ্য আপনার নিজের ভাষায় দেয়া যেতে পারে। **(Bengali)**

Ta informacja może być dostarczona w twoim własnym języku. **(Polish)**

Bu bilgiyi kendi dilinizde almanız mümkündür. **(Turkish)**

یہ معلومات آپ کی اپنی زبان (بولی) میں بھی مہیا کی جاسکتی ہیں۔ **(Urdu)**

☎ (01904) 551550

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Agenda Item 1

Health, Housing and Adult Social Care Policy and Scrutiny Committee

Declarations of Interest

Please state any amendments you have to your declarations of interest:

Councillor Doughty	Member of York NHS Foundation Teaching Trust.
Councillor Richardson	Ongoing treatment at York Pain clinic and ongoing treatment for knee operation.
	Niece is an Adult Care Manager at CYC

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City of York Council	Committee Minutes
Meeting	Health, Housing and Adult Social Care Policy and Scrutiny Committee
Date	16 October 2018
Present	Councillors Doughty (Chair), Cullwick (Vice-Chair), Cuthbertson, Flinders, Richardson and K Taylor
Apologies	Councillors Warters

30. Declarations of Interest

Cllr Cullwick declared a non-prejudicial interest in Agenda Item 6 as he currently manages a number of properties including HMO's, however none of these properties will currently be affected by new legislation.

Cllr Richardson added a standing declaration of interest in that he is currently receiving treatment from Tees, Esk and Wear Valleys NHS as well as York Pain Clinic, that had already been declared.

31. Minutes

Members requested that the following amendment be made to minute 26 (Update on the Older Persons' Accommodation Programme).

a) Amend line to read as follows:
   - "Councillors expressed their desire for best practice, regarding co-production and information sharing with Councillors and residents, to be shared with other departments in the Council"

Members also highlighted that the Standing declarations of interest for this committee should be updated in line with current membership.

Resolved: That subject to the amendment to minute 26 (Update on the Older Persons' Accommodation Programme), the minutes of the Health, Housing and Adult Social Care Policy and Scrutiny Committee held on 11 September 2018 be approved and signed by the Chair as a correct record.

32. Public Participation

It was reported that there were no registrations to speak under the Council's public participation scheme.

33. Safer York Partnership Bi-annual Report

Jane Mowat, Head of Community Safety CYC and Lindsey Robson, York and Selby Commander, North Yorkshire Police were in attendance to update the committee on the co-ordinated work of the Community Safety team and the Police.

Officers responded to a question from members on an increase in numbers of cases falling under the 'violence against a person' statistic. It was highlighted that there had been a change in the way the statistics were being recorded with harassment and stalking reports now being considered under this category.

It was also highlighted to members that the majority of the increase in numbers of domestic abuse reports could be attributed to more confidence in the police force and an increased willingness within the community to report incidents. Officers also stated the increased success and support of the Multi-Agency Risk Assessment Conferences have affected the number of reports and that this should also be seen as a positive.

Under further questioning from members regarding Anti-Social Behaviour (ASB) reporting, officers reported that whilst the police will always respond to a 'threat to life', other reports must then be prioritised. Officers pointed out that their Neighbourhood Enforcement Officers, BID Rangers and Police Officers were using the joint hub at the West Offices to ensure a multi-agency approach was being used to tackle issues such as ASB and that there had been an 80% reduction in the number of ASB cases over the last three years.

Officers also informed members of the work being done to:

- Reduce the drug paraphernalia being found by residents and businesses in the city
- Publicise a new 'text to give' campaign
- Enforce penalties against magazine sellers using inappropriate or aggressive behaviour
- Review the way in which the police and Council share information and the effect that GDPR has had

Officers explained their plan towards the future of portable CCTV cameras used to enforce on fly-tipping cases, saying that they would react to hotspots and deploy resources in areas of the city in which it was most in need.

During a discussion on administrative changes to the Channel and Prevent referral systems, officers pointed out that there had been a pilot associated with Operation Dovetail, to test the feasibility of Local Authorities organising the administration associated with these systems rather than the police. This will most likely come into effect in York at the end of 2019 or early 2020.

During the discussions, there was a recurring theme regarding how to improve the public perception of Anti-Social Behaviour in the city. With reports of the situation improving in York, members and officers agreed that there was an opportunity to join up communications and ensure that consistent messages were being sent to the public. Officers agreed to update members via email on:

- The success of the North Yorkshire Police action on cyclists not using appropriate lights
- The number of needle bins that have been distributed; and
- Information on the actions relating to inconsiderate parking around schools in the city.

Resolved: Members are asked to note and comment on the contents of this report

Reason: To update members on the performance of the Safer York Partnership

34. Update on Community Policing

The discussion of this item took place under Agenda Item 4 (Safer York Partnership Bi-Annual Report) with the Head of Community Safety and York and Selby Commander, North Yorkshire Police. Please see Minute 33 for the detail of the discussion.

Resolved: Members are asked to note the update on community policing

Reason: To ensure the committee are kept up to date on the joint working between the North Yorkshire Police and City of York Council.

35. Implementation of the Extension of HMO Licensing

Officers were present to update members on the implementation of the new HMO licensing legislation that came into effect in October 2018.

The implementation phase has included:
- The introduction of a web-based application process
- Ensuring that the teams had enough resources to deal with increased applications (around 700) and to carry out site visits
- A communication strategy around the new legislation

Officers informed members that around 60-70% of applications were now being received online.

Under questioning from members, officers highlighted the potential issues with the continued implementation of this policy. These included:
- Ensuring the quality of paperwork received in applications including gas and electrical safety certificates and working with landlords on code of practice.
- The accuracy of room sizes being declared by landlords; officers also highlighted that room sizes on the verge of not adhering to the requirements would be more likely to trigger an early inspection.

Officers stated that the rough estimate on the amount of rooms to be lost by the Council, as a result of the new minimum requirements, would be 70 out of the 495 currently licensed.

In order for the council to implement this licensing to all HMO’s, a need will have to be evidenced. Officers explained that this first three year period will be used to gather this evidence, to strengthen the argument for further extension of licensing.

Officers also explained to members that a number of databases are used to check the accuracy of self certification forms of applying Landlords.

Resolved: Members are asked to note the contents of this report and agree to support the approach outlined in the implementation policy

Reason: So that the Council can ensure that we are meeting our statutory duties.

36. Work Plan

A feasibility study has been requested on the topic of Tenant Engagement, for a potential joint review by the Health Housing and Adult Social Care and Children, Education and Communities Policy and Scrutiny Committees. An update will be brought to the meeting on the 14 November 2018.

A feasibility study has also been requested on the topic of Elective Surgery Criteria and this will be brought to the meeting of the 12 December 2018.

37. Urgent Business

No urgent business was declared.

Councillor P Doughty, Chair
[The meeting started at 5.30 pm and finished at 7.15 pm].

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Agenda Item 4

14 November 2018

Health, Housing and Adult Social Care Policy & Scrutiny Committee

Report of the Corporate Director of Health, Housing & Adult Social Care

Mental Health Support Line (MHSL) review and refresh

1. Summary

1.1 The Mental Health Support Line is based at 22 The Avenue, within the Assessment Unit which provides 5 bedsits for tenancy skills assessment for adults with mental health needs. In the first 6 months of a customer's placement the staff work alongside customers to carry out a thorough assessment of their daily living and tenancy skills. This will include work on how their mental illness impacts on their daily life and what support they have in managing these issues. This 6 months (on average) assessment will guide the next steps for the customer regarding accommodation. In general customers go on for a period of time in our supported housing accommodation to further develop and embed new skills. Most customers at the end of this period of engagement will be prioritised for social housing either with CYC or other local social housing providers. The MHSL provides telephone support and information to people aged 18 and over who need support with their mental health. We use a referral system, the majority of these referrals come from GP's and Community mental Health Teams. This service is offered to residents throughout York.

Our service offers customers:

- Time and space to talk
- Support and reassurance
- Encouragement to callers wishing to resolve problems
- Signposting to other services that may be helpful

1.2 MHSL is not a crisis line – therefore, we may call the emergency services for the caller if we feel she/he is unable to keep her/himself safe.

2. Background

2.1 The Mental Health Support Line (MHSL) was launched in June 1997, initially as a 2 year pilot project jointly funded by CYC and North Yorkshire. The funding streams for the MHSL have changed several times throughout its lifetime. However, for the last 10 years it has been solely funded by CYC. Over 7000 people have been referred to the MHSL. However there are up to100 regular callers who use the MHSL, for some this is weekly, for others daily and in a small number of cases more than once per day.

3. Rationale for review

3.1 Briefing paper to DMT in May 2018 regarding plans for changes to the residential service at 22 The Avenue including the proposal to reduce the operating hours of the MHSL - 2:00pm to 10:00pm. This will allow us to provide a more focused service to customers, and use a strength based approach in line with our Future Focus model. Currently referrals to the MHSL are open ended i.e. once a person is referred there is no end date to the access to the service. Going forward we intend to make referrals time limited with an initial access period of 2 years.

3.2 Throughout this period caller's use of the line will be regularly reviewed to establish the impact the service is having on their ability to manage their mental health needs. The work on the MHSL will focus more on encouraging callers to identify their own strengths and resources to manage their mental illness and supporting them to use these resources independently as much as possible.

3.3 This review dove tails with the proposed move of part of the service provided at 22 The Avenue to Evelyn Crescent. Risks and impacts on individuals has been considered throughout the review and discussions have taken place with key stakeholders for example TEWV.

3.4 Analysis of number of calls and callers from 2014 – 2018 has showed a gradual decline in the number of calls received during the day and overnight. We believe the development of other services in York may have had an impact such as:

- TEWV's Access to Wellbeing Service – referral by GPs and other mental health professionals. But current mental health service users can self-refer by calling 01904 526566.
- Local mental health crisis team (TEWV) – can be contacted direct on 01904 526582, open 24/7.

- Mental Health Matters (commissioned by TEWV to provide The Haven) offers a range of support through drop-in sessions at 30 Clarence St, York. Open, 7 days a week, 6pm-11pm including bank holidays.
- Mental Health Matters 24/7 Helpline People using The Haven will also be supported by 24/7 helpline. To contact The Haven call 07483141 310.
- SANEline – offers emotional support information and guidance – 4:30pm to 10:30pm 7 days a week. Tel: 0300 304 7000.
- NHS 111 – for urgent advice, 24/7.
- There are also a number of helplines with specially trained volunteers to help with immediate crisis such as: Samaritans open 24/7, MIND open 9am-5pm, Rethink open from 9:30am to 4pm Monday to Friday 0300 5000 927.
- A&E mental health Liaison Teams 24/7 - Mental Health Teams embedded in A&E and a Mental Health worker placed within the police call centre.

4. Comment from TEWV

4.1 The Haven @ 30 Clarence Street Offers out of hours mental health support to anyone aged 16 or over in York and Selby and is open 6pm-11pm every day (including weekends and bank holidays). This service is for anyone feeling distressed, frightened, overwhelmed or who's usual sources of support are closed. Find us at 30 Clarence Street, York, YO31 7EW (Opposite the Union Terrance Coach Park, next to York St. John University.)

No appointment or referral needed. Carers and family welcome.

Users of The Haven have access to a 24-hour telephone emotional support line staffed by trained counsellors.

This service is delivered by Mental Health Matters on behalf of Tees, Esk and Wear Valley NHS Foundation Trust.

4.2 Over the last 12 months the number of calls and callers at the various times of day are as follows:

2018	Calls	Total use of MHSL – including repeat callers
7:30am-2:00pm	3 to 9	1h 19

There are 2 callers who only or predominantly call the service in the morning.		
2:30pm-9:30pm	9 to 20 (Peak Time)	3h 49
Over night 10pm-7:00am There are 2 callers who only or predominantly call the service overnight.	4 to 6 (on occasions this service is not used during the night)	1h 50

(30 min gaps are to allow for handover between shifts)

5. Financial Cost

5.1 As the MHSL is staffed by a team who also deliver residential services at 22 The Avenue it's difficult to give a total cost of the service. £4,000 is the yearly cost of the equipment, software and its maintenance.

6. Initial Communication

6.1 Our aim has been to effectively communicate with key customers and stakeholders, through relevant routes, to better understand individual needs and prepare them for the proposed transition in November/December. This has included:

- Communication with all GP practices and CMHTs, requesting feedback.
- Briefing sent to chair of TEWV Service User Network (SUN) shared with members.
- Letter sent to all callers who had used the MHSL over the 6 months Jan-June 2018. The rationale for this was that many of the people referred to the MHSL have not used the service.
- Small numbers of concerns have been raised by customers. These concerns are being addressed by the management team at 22 the Avenue.

7. Further engagement & plans

- A letter has been sent to all customers identified as using the MHSL regularly over the last 6 months. Offering the opportunity for a face to face meeting in order to address any concerns and identify potential sources of support.

- 22 The Avenue staff attended the Service Users Network (TEWV) meeting to discuss changes to the service and get input into service development.

- Work with partner organisations has taken place to confirm alternative provision.

- Work has taken place with concerned individuals to develop a bespoke plan of support.

- Changes will be phased in over 6 weeks.

- During the above period, individuals have been supported with relevant referrals or assessment process if they wish to use alternative services.

- Councillors and Scrutiny members visited the MHSL service at 22 The Avenue to discuss the MHSL, this included the future approach, impact on customers and solutions to individual concerns.

8. Drop in sessions

8.1 These sessions have taken place on two dates in October. 19 people attended to discuss the MHSL. Staff talked through individual concerns and provided information regarding the approach of the MHSL moving forward and alternative provision.

8.2 All customers who attended drop in sessions, or were contacted by phone at their request were provided with information about other telephone support services and also The Haven. The locality manager from The Haven will inform 22 The Avenue if anyone presents to their service identifying that they are doing so following this intervention.

9. Individual meetings

9.1 Two customers have asked for meetings with senior staff at 22 The Avenue, these have taken place and plans have been identified to

support these individuals during the transition phase. No other additional support has been identified as a need by customers.

10. Conclusion

10.1 The review has confirmed that we need to offer a bespoke MHSL service for people needing emotional and well-being support from 2-10pm. This gives us an opportunity to refresh the service and the material we use to promote it, to ensure residents of York understand what its core functions are. We will strengthen links with customers and key stakeholders for example GPs, Practice Managers, and CMHT. Advice and information will be available through a range of sources including use of the Live Well York Website, with the aim of transforming this service late November/early December.

11. Recommendation

11.1 Scrutiny committee receive this update report as requested on 11 September

Contact Details

Author:

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Chief Officer Responsible for the report:

Michael Melvin

Interim Corporate Director –HHASC

Tel: 01904 551004

Report Approved	✓	**Date**	1/11/2018
Wards Affected:		**All**	✓

For further information please contact the author of the report

Abbreviations

CMHT- Community Mental Health Teams
CYC- City of York Council
DMT- Departmental Management Team
MHSL- Mental Health Support Line
GP- General Practitioner
SUN – Service User Network
TEWV- Tees ESK Wear Valleys NHS Foundation Trust

Home First Engagement – Initial Feedback Report

1. Executive Summary

In December 2017 the accountable officers for health and social care organisations in North Yorkshire and York agreed to undertake an engagement exercise that would begin a conversation with local people about Home First.

Three objectives were agreed for the exercise:

1. to raise awareness of Home First amongst key stakeholders
2. to ask for their views on how Home First could work in practice, and
3. to seek feedback on how best to talk to communicate with patients, relatives and carers about Home First.

Over a six month period, discussions were held with a range of community groups and networks across the Trust catchment population. In total, over 400 people took part in these discussions, 100 questionnaires were received, and 172 comments were recorded.

This report summarises the initial findings from this exercise, outlining the engagement work to date and the key themes that emerged during the discussions. It also suggests a number of next steps to take this work forward to the next stage.

2. Background

The accountable officers for the health and social care partner organisations in North Yorkshire and York recognised the need for a system-wide, large-scale engagement exercise to understand the experience of people who have been in hospital and to help patients, relatives and carers to understand the concept of Home First and discuss how this could work in relation to their care.

There are several local and national drivers for this, and we have gained some understanding of the current situation in North Yorkshire and York and this establishes the starting point for this engagement work.

These include:

- National move towards out of hospital care and reduced reliance on inpatient bed capacity;
- Local strategies for out of hospital care;
- Bed audit findings/stranded patient reviews;
- National initiatives (#Red2Green, #endPJ paralysis, #Last 1,000 days);
- Stakeholder workshops (with partner organisations);
- Focus groups.

In partnership with a number of communication and engagement leads across the local system it was agreed to work with existing groups and networks where there are already established relationships.

A discussion also took place with the Chairs and Scrutiny Officers of the York Health, Housing and Adult Social Care Policy and Scrutiny Committee and the North Yorkshire Scrutiny of Health Committee at the outset of the engagement work. The purpose of this was to inform them of the approach being taken and to understand their expectations around reporting and any further involvement. Both committee chairs were comfortable with the proposed approach and we have committed to sharing a report of our findings once finalised.

3. Engagement objectives

Three objectives were agreed for the exercise:

Objective 1: Increase awareness of Home First, and the evidence that supports it (deconditioning, the impact of harm caused to patients by extended stays in hospital) amongst key stakeholders, including patients and their families;

Objective 2: Gather feedback from patients and relatives about how a Home First approach could work;

Objective 3: Gain insights from patients, relatives and others as to how and when to communicate Home First during a patient's episode of care.

4. Overview of engagement activities

Since January 2018, we attended a range of meetings of stakeholder groups and networks, speaking to over 400 people about Home First.

These include:

- Healthwatch Assemblies
- Carers' Advisory Group (York)
- York Carers' Centre
- Scarborough Older People's Forum
- Ryedale Older People's Forum
- York Older People's Assembly
- York CVS forums (including Ageing Well, Voluntary Sector, Mental Health, Community Voices)
- GP practice patient participation groups (Haxby Group practices, Scarborough Practices, and Selby)
- Foundation Trust Council of Governors
- Ryedale U3A (University of the Third Age)

Depending on the format of the meetings, a presentation was given or a discussion was facilitated. Those attending were asked for their feedback and this was captured during the session.

A short questionnaire was also given out at each meeting. Around a quarter of those we spoke to (100 people) returned questionnaires, and a large amount of qualitative information was gathered from the sessions, including the questions asked and notes made during the discussions.

The questionnaire was also made available electronically, along with a brief article about Home First that could be shared in newsletters. This was sent to Foundation Trust members as well as contacts in the community who were able to share it via their various channels. A very small number of these were returned, which suggests that the information is best captured when people were given the chance to give their feedback there and then. The return rate dropped off significantly once people were able to take the form away and return it later.

As well as featuring as a formal agenda item at these meetings, these discussions also triggered a number of conversations through less formalised sessions.

5. Headline feedback

The first objective of this engagement work was to increase awareness of Home First.
By going out and talking to the various groups we hoped to raise awareness of the evidence that supports a Home First approach. To assess this, we asked two questions:

Q.1. Before the session today, how much did you know about this subject?
(Choose between 1 and 10, where 1 is 'I knew nothing about the subject' and 10 is 'I knew a lot about the subject').

Q.2. After hearing the session today, how much do you feel you now know about this subject?
(Choose between 1 and 10, where 1 is 'I know nothing about the subject' and 10 is 'I know a lot about the subject').

The average response for question 1 was a score of between 3 and 4 (mean score = 3.68). The average response for question 2 was a score of between 6 and 7 (mean score = 6.52). This indicates that by presenting the information to people, involving them in a discussion and asking them to share their experiences and feedback of using our services, we were able to increase awareness of Home First amongst these key stakeholders.

Objectives 2 and 3 were to gather feedback about how Home First could work, and how and when it could be best communicated. As well as gathering general feedback from the discussions at the sessions, we asked two further questions on the questionnaire:

Q. 3. Now that you have heard about Home First, and given your experience, how could we make Home First work in practice?

Q. 4. How could we explain to people about why Home First is important to people in hospital, their families and their carers?

These were open questions, and 172 comments and suggestions were received in total.

The groups we spoke to were supportive of the principles of Home First.

"Most people would rather live in their own homes as long as possible so wouldn't need much convincing."

"Most would want to go home. I would feel better as soon as I went through my own front door."

"I think we would all agree that hospital beds should only be occupied by people needing hands on nursing and medical supervision."

Where concerns were voiced, they were not about the approach, but rather about capacity, suitable assessment, availability of funding and staff. People were concerned about fail safes and backstops - what if something goes wrong or there is an emergency?

"However people need to be confident that there will be sufficient support at home, not just 'left'. We often hear about people getting home and not knowing when follow up appointments are, who's coming in, who to contact if it not working."

People also wanted assurance that those receiving home-based care are not disadvantaged by not being in hospital, for example are their nutritional needs being met in the same way?

"Simple things like food and time spent with patients is important."

6. How can we make Home First work?

The responses on how we can make Home First work in practice fell into seven main themes:

6.1. The need to involve carers/families in decision making

This was thought be important by members of the groups we spoke to. Giving carers the opportunity to have an input is something that it was felt may make the transition to home easier.

"Talk to the family/carers in plenty of time - what can/can't they do - what support will they need as well as the patient. Work together, for example involve them in meeting planning."

"Families need to be involved in their loved ones care and decision making."

6.2. Communication - both with patients and carers and between professionals

Being clear about what is happening next when people leave hospital was felt to be key to allaying concerns and helping people understand what is happening and why. Comments were also made in relation to improving communication between different parts of the system.

6.3. The importance of recognising and assessing patients' individual needs and circumstances

There was a clear desire amongst patients that they want to receive care that is personal to them, and to be treated as an individual. They did not want their preferences to become 'lost' when they go home.

6.4. Pre-planning as early as possible for what will happen when someone leaves hospital - particularly if their admission was planned

There were some examples that were fed back of when people have gone into hospital for a planned procedure and felt that planning for what happens when they go home could have been better.

6.5. The need for joined-up working

There was a clear call for working together, integration, and sharing resources and information. There was also recognition of the important role the third sector plays in this sort of care.

"Ever closer cooperation between NHS hospital care and local authority care system."

"Closer liaison between hospitals and care providers should ensure care needs after leaving hospital are not overlooked."

"Ensure all agencies work together and do not bounce patients and their carer round the system."

6.6. Recognition of the impact on families and carers

There was discussion of the potential risk of over-reliance on carers and families, but also recognition of the invaluable work they do and how it can often be unacknowledged or unaccounted for. They are a source of knowledge and should be involved in discussions and decisions about care, along with the patient.

6.7. The issue of social isolation

It was clear from the feedback and in talking to the groups we attended that loneliness and social isolation are considered to be significant problems and a real potential barrier to people being comfortable with a Home First approach. However, it was also clear that the overwhelming

majority of people we spoke to agreed with the approach and believed that most people would rather be at home than hospital.

“Not everybody is lucky enough to have relatives or good friends who could respond.”

7. How might we communicate?

There were also a number of clear themes in the responses to how best to communicate with patients, families and carers, how best to get the message across, and what that message might be.

7.1. Be clear about the rationale:

On several occasions people said that we need to be clear that this is not about closing beds or hospitals, or indeed saving money or cutting services.

“You’d need to dispel cynicism that this is just about increasing throughput to save money.”

7.2. Be clear about what Home First is (and isn’t)

A large number of the responses suggest a gap in understanding as to what Home First might be. Comments such as *“not everyone has a family capable of looking after a sick person. I live on my own, my daughter is 200 miles away”* and *“presumably this isn't just for people who live alone - so carers/families need to know about reablement/physio - how to support the person - so they don't just ‘do it for them’”* could suggest that people think the intention is to remove or reduce care someone might have received if they had staying in hospital, or to expect friends or family members to take this on.

This suggests that Home First should be explained in a way that helps people to understand that it is about rehabilitation, recovery, and avoiding harm, rather than long term care or nursing needs. It is not about replacing the care given by professionals with family or volunteers, we are re-providing this in people’s homes, using the appropriate staff.

7.3. The evidence is an important tool

People fed back that the evidence and data presented regarding harm caused is compelling and should be used to help explain why people should not remain in hospital longer than necessary.

7.4. Changing the culture amongst staff

Another key theme was around making sure staff understand and support Home First, as they are a key conduit for information and a trusted source. This should not just include hospital staff, but GPs and other health and social care professionals.

"A bit of a culture change across staff within health as a whole, to emphasise the risks inappropriate hospital use can raise."

"[Communicate] through the people that are going to be on the front line."

7.5. What sort of materials could be useful?

People suggested some practical approaches to getting the message across, with many people favouring literature and leaflets, preferably to be given whilst in hospital. Using the media, and potentially 'real life' case studies, was another recurring theme, along with the development of a campaign, with the phrase 'use it or lose it' being mentioned on more than one occasion.

8. Recommended next steps

The recommended next steps following the review are:

1. Present the results to the commissioning health and social care organisations;
2. Present the results to the City of York Overview and Scrutiny Committee and share with the chair of the North Yorkshire committee;
3. Work with partner organisations to develop suggested responses to the themes identified (either ongoing work or new developments);
4. Carry out the second phase of the engagement exercise to present the results and suggested responses back to a range of stakeholder groups, this will include challenging groups as to what they can do to address the issues raised.

Healthwatch York: Performance Monitoring / Six Monthly Review

Name of Provider	York CVS
Service Provided	Healthwatch York
Contract Start Date (Service Commencement Date)	01 April 2017
Contract Finish Date (Expiry Date)	31 March 2020

1. The aims of the performance monitoring / six monthly review process are to:

   - *Review the achievements of the Service in delivering the agreed outcomes*
   - *Consider how the Service might be developed going forward*
   - *Identify how beneficiary needs are being delivered*
   - *Establish that the Service is being managed in accordance with the Agreement*

2. *The information contained in this report will be used as a basis for the Annual Service Review, in conjunction with that information provided on a regular basis during each year of the Term.*

3. *Six monthly performance monitoring reports will include a mixture of qualitative and quantitative data to ensure that the process is not simply a mechanistic one, but feeds into a continuous cycle of improved performance. Six monthly reports will be presented to Performance Management Group meetings on dates to be agreed.*

4. *In addition, a six monthly performance management meeting will be held between representatives of the Council and Healthwatch York. The performance management group meetings will:*

   - *Agree additional Key Performance Indicators that will constitute six monthly performance summaries*
   - *Set annual milestones for each Key Performance Indicator as appropriate*
   - *Receive six monthly performance summaries, define any gaps in performance and discuss how these might be rectified.*

5. In addition to the six monthly reporting process it is proposed that 360 degree feedback on Healthwatch York activity is invited from all key stakeholders annually.

Signature on behalf of Provider		
Signature Catherine Scott	Name Catherine Scott	Date 01/11/18
SECTION 1: Service Provided 01/04/18 - 30/09/18		

6. What have been the main focus areas of Healthwatch York during the last six months?

Qtr 1

- Scoped work for a possible consultation project around the creation of a health centre at Burnholme Community Hub
- Went out and about in the community with mobile Explore library bus
- Healthwatch volunteers took part in PLACE visits
- Delivered Care Home Assessor training to 3 new volunteers in conjunction with City of York Council
- Supported the Universities of Sheffield, Hull and York to hear patient views on advanced roles in primary care, to help shape future training for Advanced Care Practitioners.
- Recruited an interim Manager for Healthwatch York
- Moved to a private office space in the licensee area of Priory Street Centre
- Printed new editions of our signposting guides “What’s out there for people with dementia, their families and friends in York” and “Mental Health and Well Being in York”
- Published our 5th Annual Report on 30 June 2018
- Completed our annual stakeholder evaluation

Qtr 2

- Held our 5th Annual meeting on 24 July, attended by over 50 people
- Drafted our report: LGBT+ people’s experiences of health and social care services in York
- Recruited a new Healthwatch York partner, Re:shape
- Ran our annual volunteer development session

- Recruited a Research and Engagement Officer for Healthwatch York

Key Performance Indicators to include:

- *The impact of Healthwatch activity on community / commissioners / service providers – including progress towards Public Engagement Reports, involvement in key strategic meetings.*
- *Feedback mechanisms used by Healthwatch to inform participants and the wider public on the outcomes of the issues covered by Healthwatch.*
- *Communication and Reach - evidence of public, patient, carer and user-group engagement with / participation in Healthwatch*
- *Financial / Spend monitoring*
- *e.g. The number, frequency and type of methods used by the Host to engage with individuals, organisations and groups. (captured in quarterly Information and Signposting Reports)*
- *The outcomes of any visit to Health and Social Care premises in York.*

7. *What progress has been made during the last quarter in respect of the above? Have you identified any barriers to achievement of agreed outcomes?*

Impact of Activity / Public Engagement Reports

Impact of activity:

8. Our Annual Meeting in July aimed to share the impact of our work with interested parties. This year we focussed on:

- What people told us for our dental report, and changes to services as a result
- The work of our readability volunteers and our partnership working with York Hospital
- How we capture feedback from people, and what we do with that information
- We learnt about the newly launched Safe Places Scheme

- We ran a workshop asking for views and opinions on Changes to Services, our workplan item for this year
- We learnt about the Live Well York website. Healthwatch York has been working with CYC on the development of the Live Well York website as part of our signposting and information role.
- Our plans for next year

9. We also presented our annual 'Making a Difference' awards. These celebrate individuals, teams and organisations that are making a difference to people's experience. This year we made 26 awards to 10 organisations. Representatives from 5 organisations collected awards in person.

10. The Making a Difference Awards were covered by the York Press

https://www.yorkpress.co.uk/news/16592291.going-above-and-beyond/

11. We asked A E Portz Associates to complete our independent stakeholder evaluation, as required by our contract. They provided the following report: https://www.healthwatchyork.co.uk/wp-content/uploads/2014/06/Healthwatch-York-Evaluation-Report-2018.pdf

12. We had 27 respondents, and the key findings from the report were generally positive, with sufficiently robust evidence to support the following statements:

    - The statutory and other partners of Healthwatch York believe that HWY meets its stated aims of involving the public and service users in York to ensure their views and experiences are highlighted to services in a way that can bring about change
    - Healthwatch York is considered to contribute to improving health and social care services in York
    - Healthwatch York is believed by its stakeholders to influence health and social care services in York, and stakeholders can provide specific examples of where this has been the case.

13. Results from the questions include:

- 60% (15 of the 25 respondents) agreed that health care services in York have been improved as a direct result of the work of Healthwatch York.
- 56% (14 respondents) agreed that social care services in York have been improved as a direct result of the work of Healthwatch York with this statement, with 11 neither agreeing or disagreeing (44%)
- 80% (20 respondents) in agreed, and 20% (5 respondents) neither agreed or disagreed that health care services in York have been influenced as a direct result of the work of Healthwatch York.
- 74% (17 respondents) agreed and 26% (6 respondents) neither agreed or disagreed that social care services in York have been influenced as a direct result of the work of Healthwatch York. This was as substantial increase on previous years. Comparison of the results for the past 3 years shows an increase on 2017 and a substantial increase on 2016:

	2016	2017	2018
In agreement with Q5	48	62.5	74

- 80% said that Healthwatch York is responsive to the needs of York's residents
- 84% said Healthwatch York understands what is happening in relation to health and social care services in York
- 96% said Healthwatch York speaks up about the provision of health and social care services in York
- 88% said Healthwatch York uses stories of service users to show the impact of health and social care services in York
- 92% said Healthwatch York involves the public in the work they do
- 88% said Healthwatch York involves partners and service providers in the work they do
- 92% said Healthwatch York advocates for people's involvement in their health and social care
- 44% said Healthwatch York has reached new people
- 80% Healthwatch York provides an effective service for the people of York using health and social care services

14. We also ran an awareness survey for members of the public. Details of this can be found here:

https://www.healthwatchyork.co.uk/wp-content/uploads/2014/06/Healthwatch-York-Awareness-Survey-2018.pdf

15. The conclusion of the report was that Healthwatch York still needs to be more visible across the city. A good proportion of people were unaware of the support Healthwatch York offers. This includes reporting experiences and providing signposting. The range of ways that people have heard about Healthwatch York shows the importance of partner organisations and our information stands in raising awareness. However, the responses highlight that we still need to look at ways of raising awareness among a wider range of people across the city. This includes reaching a wider age demographic, and has further cemented our commitment to improve our profile among students and young people, with a number of outreach initiatives planned for the start of the 2018/19 academic year.

Key strategic meetings

16. We held an initial engagement event at Tang Hall Community Centre on 4 April 2018 about the potential development of a Priory Medical Group Health Centre at Burnholme Community Hub. This was to both inform the public about the developments, including the potential closure of three Priory Medical Group surgeries if the health centre were to go ahead, as well as gather the views of the public to inform future engagement work around this. The event was attended by approximately 20 people, and included a detailed presentation from Priory Medical Group about how the new health centre could look.

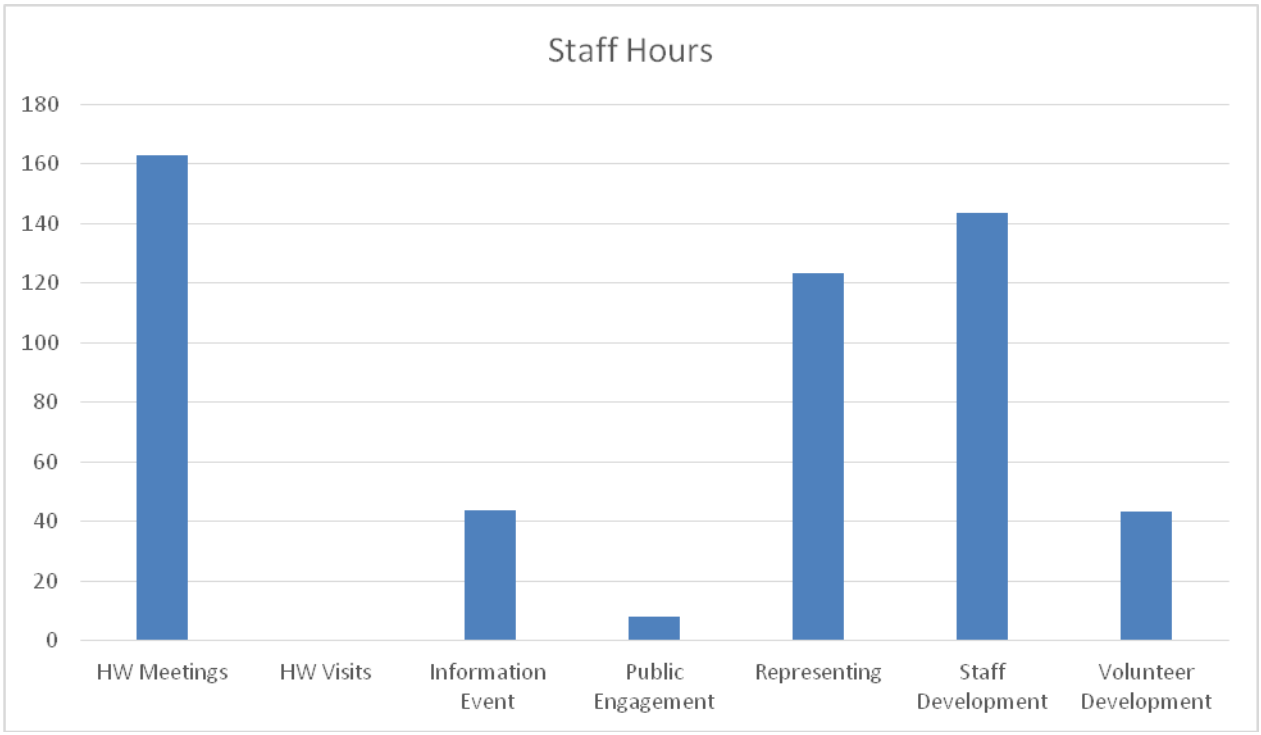
17. Although further engagement around this is on hold due to the delays in obtaining funding for Priory Medical Group to go ahead with the project, we are better informed of the key questions we should be asking in our survey, as well as the best approach to engaging those who could be affected by these developments.

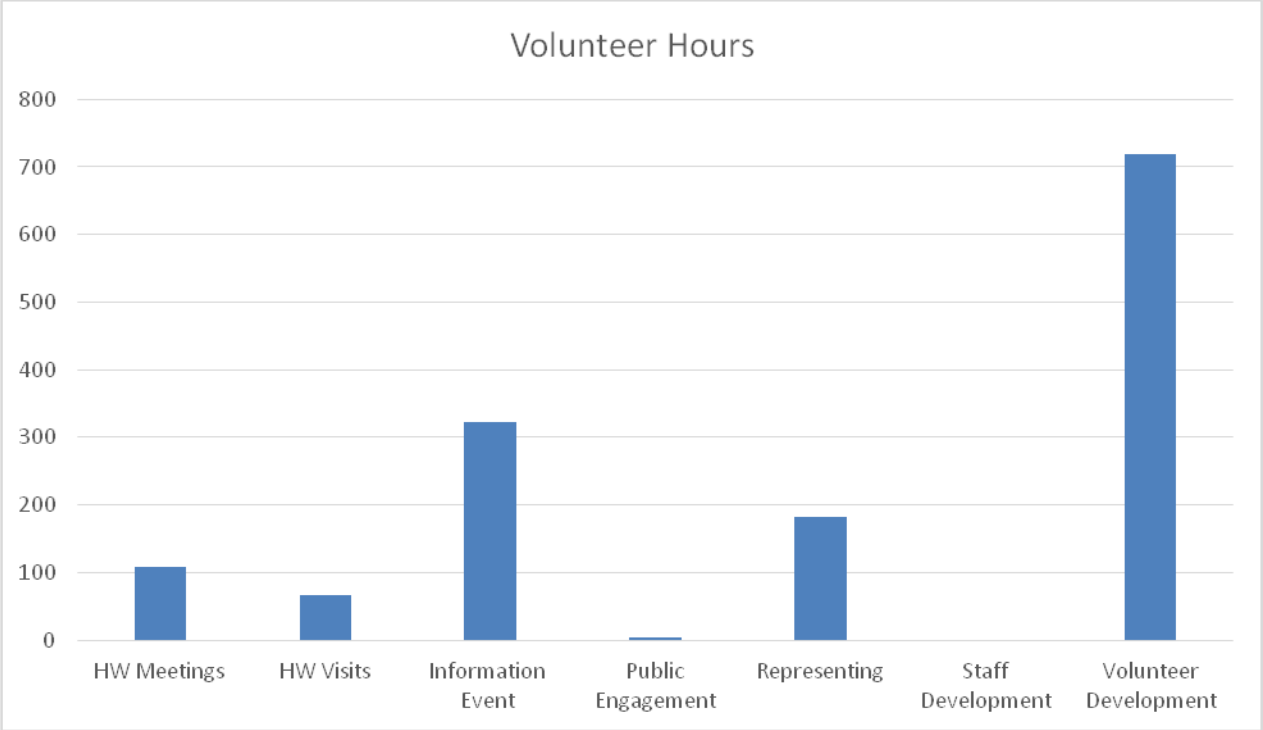
18. We supported a Vale of York Clinical Commission Group stakeholder and public engagement event on the reprocurement of the Adult Autism and ADHD Assessment and Diagnostic Service.

19. We are working in partnership with Changing Lives, York Pathways and Lankelly Chase to create and co-facilitate a Multiple Complex Needs Network for York. We are in the early stages of developing this network, but have positive engagement from a number of organisations from across the system. The Network is keen to work together to improve outcomes for people with multiple complex needs across the city of York, and we will continue to support the development of this work.

Communication, Engagement & Reach

20. Staff and volunteer hours by meeting type is detailed below:





21. For more details regarding our engagement work, we are happy to share our engagement calendar, giving details of all events we have held and participated in.

22. During strategic meetings, both Healthwatch York staff and volunteer representatives complete Reps Reports. These reports can be found here:

    https://www.healthwatchyork.co.uk/wp-content/uploads/2018/08/May-2018.pdf (this actually covers April and May)
    https://www.healthwatchyork.co.uk/wp-content/uploads/2018/08/June-2018.pdf
    https://www.healthwatchyork.co.uk/wp-content/uploads/2018/08/July-2018.pdf
    https://www.healthwatchyork.co.uk/wp-content/uploads/2018/08/meeting-reports-2.pdf

Outcomes of visits to Health and Social Care premises in York

23. Due to staff illness within the Adult Social Care team the care home visits programme was on hold for several months. Visits were resumed in September with more visits scheduled for October. Our care home visits contributed to and enhanced 2 City of York Council care home reports, having engaged with 12 residents in total.

Readability Work

24. Our readability volunteers have an interest in supporting local providers and commissioners to improve their patient information. Over this half year we have reviewed 19 documents, 15 for York Teaching Hospital, and 4 for City of York Council. The group also commented on the functionality and ease of use of the Live Well York website. Susan Manktelow Patient Information and Policy Support Administrator, York Hospital also spoke at our Annual Meeting. She spoke positively about the added value our volunteers bring to their Patient Information leaflets.

Partner Programme

25. We have 40 voluntary and community sector organisations who are signed up as Healthwatch York partners, and 2 pharmacy partner organisations. We invite our partners to our quarterly Assembly and Annual Meeting to get involved in conversations about what is happening locally in health and social care. We also work closely with them to progress our work plan reports. Our newest Healthwatch partner is re-shape (https://www.re-shape.org.uk/). They will be running some training about their work to Healthwatch York staff and volunteers.

Volunteers

26. At the end of March 2018 we had 46 volunteers covering a range of volunteer roles. These include Representatives, Community Champions, Enter & View, Care Home Assessor, Research, Marketing and Communications, Readability Panel, Office Support and Leadership Group members, plus our Ways to Wellbeing (W2W) volunteer role, in partnership with the W2W Co-ordinator at York CVS.

27. We continue to support volunteers with regular meetings, both for all volunteers and specific meetings for certain roles. To mark Volunteer Week in June we presented all our volunteers with a certificate in appreciation for all the work they do for us.

28. In September we asked the independent organisation, Finding Perspectives, to run a volunteer development session. This focused on exploring volunteers' skills and interests, why they volunteer and

how they support and help Healthwatch York to be successful. We had positive feedback from this session, with volunteers eager to explore volunteer opportunities they had not previously engaged with at Healthwatch York.

29. We continue to work in partnership with Ways to Wellbeing, supporting their volunteer recruitment, development and training.

Engagement

30. We continue to carry out community engagement activities at events and locations throughout York.

31. Our regular outreach is going strong, with monthly drop-ins at Lidgett Grove, St Sampsons café for 60+, Café Nelli, Fulford Church, Oaken Grove Community Café, Acomb Library, West Offices, Ellerby's Hub at York Hospital, and Church of Holy Reedemer.

32. Our volunteers are a regular presence at many community venues, signposting people to services across the city and recording people's experiences of health and social care services.

33. Every month we also provide one-off information stands at different locations around the city (eg the University of York Student Wellbeing fair and Fish and Chip Friday).

34. In August one of our regular venues, Spurriergate café, closed down. We are currently looking for a replacement venue in a similar location.

35. We have been involved with the York Explore Mobile Library, travelling to locations across the city. This has allowed us to engage with people from different demographics, helping us capture the views and experiences of people we haven't previously heard from.

36. We also supported a number of events celebrating 100 years of the NHS, including the NHS 70 party, and travelling around York with York Explore Mobile Library.

37. We have sent out 1 quarterly magazine in Spring 2018. This was produced and distributed by post to 320 individuals and 23 organisations and by email to 889 individuals and 135 organisations. It was also available through our website, and was distributed at our information stands at community venues.

38. Following from changes to Data Protection Law at the end of May our mailing lists reduced in June. We posted our 2017-18 Annual Report to 56 organisations and 274 individuals, and it was emailed to 343 people. We also distributed paper copies at our information stands at community venues.

39. @healthwatchyork has now got 2211 followers showing a continuing steady increase since March 2018. Over the 6 months from April to September we gained 43,100 twitter impressions, 139 retweets, 177 link clicks and 116 likes. Our top tweets for each month were:

- September: If you are struggling at university with your **#MentalHealth** then our York Mental Health and Wellbeing guide has a student support section. **#UniMentalHealthDay** **@UniOfYork** **@YorkStJohn** https://www.healthwatchyork.co.uk/wp-content/uploads/2014/06/Mental-Health-Guide-Issue-3v2_web.pdf …

- August: A **#free** all day event 'Thinking about health and people with learning disabilities' on 20th September. See here for more info - https://www.healthwatchyork.co.uk/news/thinking-about-health-and-people-with-learning-disabilities-event/ …

- July: Lets hope the sun is shining while we are at Copmanthorpe **#carnival** this Saturday. We will be there along with many other fun things to get doing.

- June: Are you a healthcare professional? Want to create long lasting change? Yes? Lead the way in making small changes that make a real difference to people with a **#LearningDisability**. Become one of **@Mencap_Charity**'s **#TreatMeWell** champions! http://bit.ly/2JBswDz **#LDWeek18**

- May: 

Our new guides are here! The issue 3 **#mentalhealth** and issue 2 **#dementia** guides are finally with us, very exciting news *silent eek* Please contact the

@**healthwatchyork** office if you would like a printed copy! pic.twitter.com/7dhFN4hOwr

- April: Early diagnosis really does save lives, that's why this April @**Bowel_Cancer_UK** and @**bowelcancer** are raising awareness of bowel cancer symptoms. And you can help spread the word too, find out how: https://www.bowelcanceruk.org.uk/bowel-cancer-awareness-month/ …

Logging issues

40. We logged 87 issues. This includes some double counting as people may talk about two or three different organisations within one issue and they are logged against organisations.

Key themes from the reported issues and feedback centre

41. Access to services:

- Difficulty in getting a GP appointment, including waiting times for an appointment, and the issues with the phone line and online appointment system at Unity Health practice.
- Difficulty in finding an NHS dentist in York
- Waiting times for Child and Adolescent Mental Health Services (CAMHS)
- Poor physical access to services, including impact of lift being out of service at York Teaching Hospital

42. Changes to Services:

- Reduction in or changes to care packages by CYC
- Negative impact of not being allowed surgery due to BMI/Smoking threshold levels
- Changes to which items are able to be prescribed
- Changes to providers of medical equipment or supplies, for example changes to the provider of incontinence pads
- Concern over what the impact of closures of services might be – The Retreat; Priory Medical Group surgeries; reduction in hours of mental health support line
- Change of support services for people with learning disabilities at Burnholme Community Hub

- Concern for physical and mental health of NHS staff due to pressures they face

43. Quality of Care/Treatment Received:

- Poor care/treatment:
- Lack of continuity of care in care home
- Problems experienced with discharge from York Teaching Hospital
- Poor experiences of getting a diagnosis and subsequent care for a number of conditions
- Poor care received when accessing CAMHS
- Dementia – care following diagnosis – some positive experiences of voluntary sector organisations, some negative experiences of support from NHS
- Integrated Hospital Care Team – problems with care/support following discharge
- Positive care/treatment:
- Good experience when seeing dentist
- York Teaching Hospital – dermatology, emergency department; eye department
- Good paediatric care
- Positive impact of Healthwatch York signposting service

Signposting and advice

44. We continue to record signposting activity through the issues log where this is received in the office via phone calls or emails.

45. We keep a full log of all signposting contact through community activities and events, much of which is through our Community Champion volunteers. They have been at events attended by over 5886 people, speaking with 727 individuals.

46. We signpost to a large number of health and social care organisations and services in York, including the “Big 6” (Dementia Forward, First Call 50+, Family Information Service, York CAB, York Carers Centre, York Mind). We also share information from and about York Advocacy, particularly their NHS Complaints Advocacy service. We have given out over 100 leaflets covering mental health, dementia, older people’s services, caring, young people and public health.

47. We provide signposting to complaints procedures for key health and social care organisations and services in York.

48. We created issue 3 of our Mental Health and Wellbeing Guide distributing over 520 printed copies to individuals and organisations. We also created issue 2 of our Dementia Guide and we distributed over 380 to individual and organisations. We have heard from many individuals and organisation how valuable both of the new and updated guides. We have also given out over 100 Healthwatch York leaflets, helping to increase awareness of Healthwatch York.

Future Developments

49. We are continuing to develop our work around changes to services. We have been doing some background research into anti-coagulation clinic changes, BMI/smoking thresholds and IAPT, and will be launching a survey at the start of October 2018.

50. We continue to wait to hear of developments with the Priory Medical Group funding for a health centre at Burnholme Community Hub before going ahead with our public consultation. We are also looking at options for developing other engagement work in the area if the wait for funding continues beyond 2018.

51. We will be publishing our report on LGBT+ people's experiences of health and social care services in York at the beginning of October 2018, and will present it to the York Health and Wellbeing Board on 17 October 2018.

Barriers

52. We continue to be concerned about access to information in a 'digital-by-default' society, and it presents particular challenges for us as a signposting, information and advice service.

53. This half of the year has also been challenging with low staff capacity at times, reducing from 4.2 full time equivalents at the end of 2017 to 2.4 at the end of September 2018. As a result we have been selective in the work we have been focused on during this time. We have now appointed of 2 new members of staff, and will be appointing a third in October 2018.

SECTION 2: Staff training and development / Healthwatch Volunteers			
Course title	No's Of Staff / volunteers Attended	Refresher Yes	No
• Managing Challenging Behaviour	4		✓
• Healthwatch England Call Handling training	3		✓
• Accessible Information	1		✓
• Public and Patient Voice training	1		✓
• Good Conversations training	2		✓
• Safe TALK training	1		✓

54. There have been a number of staff changes over the last 6 months following the departure of Siân Balsom, Manager, on family leave in April 2018.

55. Catherine Scott, former Policy and Research Officer, started as interim Manager in June 2018 following a successful York CVS internal recruitment process. She has picked up much of the work Siân Balsom was carrying, including attending a wide range of strategic meetings, maintaining the presence at the Health and Wellbeing Board and other partnership boards within the City of York area. She has supported the development and restructure of the staff team, and the successful recruitment of two new members of staff.

56. Helen Patching, Project Support Officer, provides administrative support for Healthwatch York, including coordination of all internal and external Healthwatch York meetings. She leads the Readability programme, and has recently taken the lead on our lay visiting programmes – the care home assessor programme and PLACE visitors programme. Helen has also played a significant role in the coordination and creation of our quarterly magazine and annual report, coordinates all staff and volunteer training, and is working to make sure that all Healthwatch York publications meet the Accessible Information Standard.

57. Abbie Myers was our Business Admin Apprentice from August 2017 to September 2018, working to support our information stands, volunteer monitoring and some of our communications work. She joined the team formally as the Community Engagement

Coordinator at the end of September 2018, and is now leading on all community engagement initiatives, and is looking in particular at how we can expand our reach to young people in York.

58. Sandra Forbes joined us as Research and Engagement Officer in August 2018. She is currently focusing on our work around changes to services, as well as supporting our research volunteers.

59. John Clark, our Chair, has continued to chair our Leadership Group meetings, creating a helpful and supportive environment within which to discuss the challenges of delivering a successful Healthwatch. He is also now our substitute on the Health and Wellbeing Board, as well as attending the Voice and Involvement Group meetings co-ordinated by City of York Council. He chairs our Assembly meetings, making sure volunteers, partners and key stakeholders have opportunity to debate key issues in health and social care, and raise matters of concern or interest. He has provided considerable support to the staff team, and providing a level of stability during this turbulent year.

60. We said goodbye to Oliver Athorn, Information, Signposting and Advice Officer, in September. Oliver has worked hard to improve our signposting, information and advice service, and smoothly guide Healthwatch York through the implementation of the new General Data Protection Regulation.

61. Due to the departure of Sarah Armstrong, former York CVS Chief Executive, and Joanne Abbott, former York CVS Finance Officer, there was some temporary reduced capacity and increased pressures within York CVS senior management team. We have continued to receive support from Jane Hustwit, York CVS Chair of Trustees, Karen Weaver, HR advisor, and Helen Carr, York CVS Head of Delivery, and thank York CVS for their ongoing commitment to Healthwatch York.

Staff Support	
How often are staff meetings held?	We continue to hold monthly team meetings, to plan and co-ordinate our work. In addition, we have held a number of team development sessions, facilitated internally and externally, to look at staff roles and work load. We regularly attend York CVS weekly comms huddle.

How often do staff receive supervision from a senior?	At least every 6-8 weeks.
How often are staff formally appraised?	We have completed annual appraisals in the past, and are currently reviewing our systems.
Number of staff appraised in last period:	0
Complaints/Commendations about Healthwatch York	
How many informal complaints have been received?	0
How many formal complaints have been received?	0
SECTION 3: Additional Comments	

Draft finances (October 2017 – March 2018)

	Budget	Actual	Variance	Explanation of over spend
Staff Costs (Salaries & Expenses)	40,814	43,354	-2,540	Overspend due to staff support needed following loss of colleague, and consultancy costs following team member going on family leave
Volunteer Expenses	1,530	1,556	-26	Overspend due to extra duties taken up by volunteers that were previously done by staff following staff changes
Local Administration	11,323	11,323		

Other	11,408	14,779	-3,371	Overspend due to purchasing of equipment needed following office move, and reprint of mental health and dementia guides.
Total Expenditure	65,075	71,012	-5,938	Paid for by funds brought forward/other income

*Please note these figures are unconfirmed as we continue to complete our end of financial year processes, and therefore may be subject to change.

Abbreviations

ADHD- Attention Deficit Hyperactivity Disorder
BMI- Body Mass Index
CAB- Citizen's Advice Bureau
CYC- City of York Council
CVS- Community volunteer Services
HWY- Highways
IAPT- Improving Access to Psychological therapies
LGBT- Lesbian, Gay, Bisexual and Transgender community
NHS - National Health Service
W2W- Ways to Wellbeing

14 November 2018

Health, Housing & Adult Social Care Policy & Scrutiny Committee

Report of the Director of Public Health

Suicide Prevention and Self-harm Overview Report

Summary

1. The scrutiny committee requested that a report on suicide prevention and self-harm be brought to the November meeting.

1.2 This report provides a summary of progress and recent activity in relation to these two areas of focus.

1.3 The report also identifies opportunities for further development to strengthen our responses to these issues

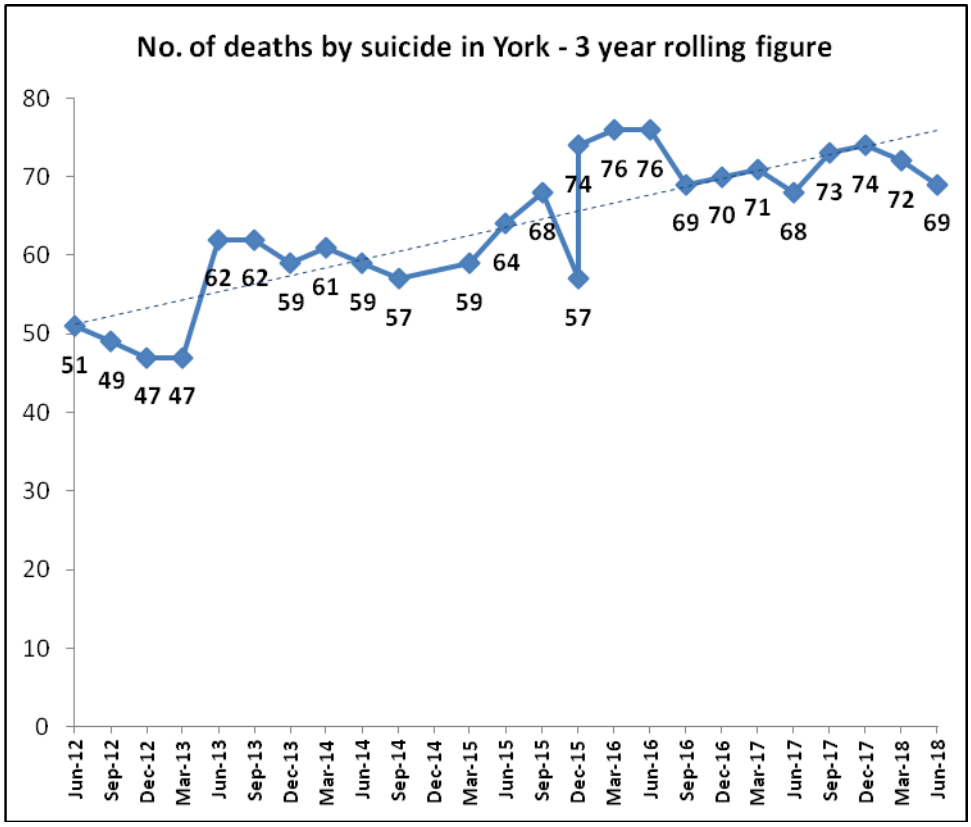
Background

2. At recent scrutiny committee meetings, there have been several requests made to understand the local picture around suicide within the City.

2.2 Within the local All-age Mental Health Strategy, suicide prevention has been identified as an area of local priority due to the identification of higher rates of suicide reported for York when compared to regional and national rates.

Latest Trends in Death by Suicide

2.3 The three year rolling number of deaths by Suicide (including events of undetermined intent) has risen in York over the last 6 years. The peak was 76 deaths in the three year period to June 2016. There has been a slight fall to 69 deaths in the most recent three year period (to June 2018).



Source: Primary Care Mortality Database

Premature deaths among people with severe mental illness

2.4 The Disability Rights Commission has reported on serious inequalities experienced, in terms of reduced life expectancy, by those with severe mental illness.

2.5 The excess mortality rate in adults with serious mental illness in York is slightly lower than regional and national averages however this indicator has not been published since 2014/15.

2.6 We know from an audit into deaths by suicide of York residents over a 5 year period that was conducted in 2016, that deaths from suicide represent a significant premature loss of life.

2.7 The sixty people included in the audit taken together were deprived of 2,249 ‘years of lost life’, around 37 years per person, as a result of suicide.

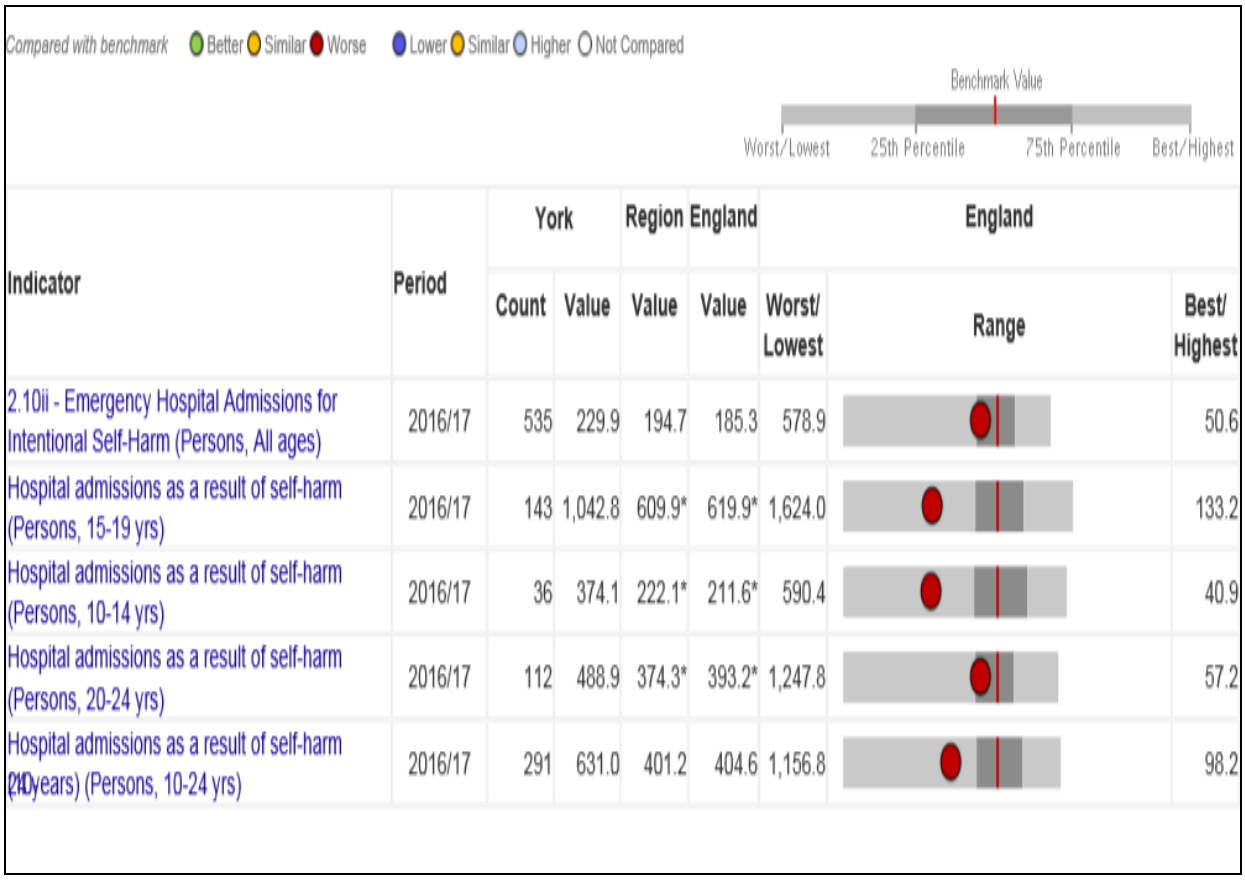
Self-harm

2.8 Within a recently developed ‘Suicide Safer Community 2018-2023’ strategy (annex 1), self-harm is identified as a priority area of focus

because of an associated increase in risk of suicidal ideation, suicide attempts, or completion of suicide by those with a history of self-harming behaviour.

2.9 The topic of self-harm has been identified as one of three key priority areas of the Mental Health Partnership as part of its delegated remit to achieve the objectives of the All-age Mental Health Strategy.

2.10 Locally, self-harm rates based on hospital admissions connected to self-harming behaviour within our population are higher than both regional and national levels:



Indicator	Period	York		Region	England	England		
		Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
2.10ii - Emergency Hospital Admissions for Intentional Self-Harm (Persons, All ages)	2016/17	535	229.9	194.7	185.3	578.9		50.6
Hospital admissions as a result of self-harm (Persons, 15-19 yrs)	2016/17	143	1,042.8	609.9*	619.9*	1,624.0		133.2
Hospital admissions as a result of self-harm (Persons, 10-14 yrs)	2016/17	36	374.1	222.1*	211.6*	590.4		40.9
Hospital admissions as a result of self-harm (Persons, 20-24 yrs)	2016/17	112	488.9	374.3*	393.2*	1,247.8		57.2
Hospital admissions as a result of self-harm (10-24 years) (Persons, 10-24 yrs)	2016/17	291	631.0	401.2	404.6	1,156.8		98.2

Source: Public Health Outcomes Framework

Consultation

3. A wide range of consultation has been completed concerning the agenda's of suicide prevention and self-harm.

Suicide Prevention

3.1 In developing our recent 'Suicide Safer Community 2018-2023' strategy; consultation was completed in a range of ways which include: at the

2017 Suicide Prevention conference; through targeted engagement by the Suicide Prevention Co-ordinator with key stakeholders; through engagement with members of a North Yorkshire and York Suicide Prevention Task Group; a workshop consultation event funded by York Samaritans held in the summer of 2018; a full public consultation process about the content of the draft strategy; and through consideration of and alignment to key priorities within the National Suicide Prevention Strategy; and through alignment with the framework of the 'Suicide Safer Communities' approach in relation to the 'pillars of action' which outline specific areas of focus that contribute to the creation of a community level response to suicide prevention.

3.2 The achievement of a community that is able to be 'Suicide Safe' is an overarching principle behind the York 'Suicide Safer Community 2018-2023' strategy and our local approach.

3.3 The Suicide Safer Community 2018-2023 Strategy identifies 9 key priority areas:

- Reducing the risk of suicide in high risk groups
- Tailoring approaches to improve mental health in specific groups
- Reducing access to means of suicide
- Providing better information and support to those bereaved or affected by suicide
- Supporting the media in delivering sensitive approaches to suicide and suicidal behaviour
- Supporting research, data collection and monitoring
- Reducing rates of self-harm
- Training and awareness raising
- Preparedness and post incident management

3.4 These areas of priority were widely consulted on during the development of the strategy. An action plan that provides the detail around how these strategic objectives will be achieved across the City is being developed by a re-shaped York Suicide Safer Community Delivery Group which will report to the York Mental Health Partnership. Membership is being established to ensure it is appropriate.

Self-harm

3.5 In relation to self-harm, a needs assessment and audit through the Child and Adolescent Mental Health Service (CAMHS) which looked into

hospital related self-harm need in young people was completed in 2016 (annex 2). This identified some key areas for action and focus which were informed by wide consultation within the local health and social care system. The creation of a self-harm guide by the Strategic Partnership, Emotional & Mental Health (annex 3) was produced through multi-agency collaboration.

3.6 At the most recent Mental Health Partnership meeting, the Joint Strategic Needs Assessment (JSNA) Working Group was tasked with completing a needs assessment into self harm to help further understand the local profile.

3.7 At the time of writing this report, recommendations about the method and scope of this approach through the JSNA process have yet to be defined. However, given the content of previous needs assessment content, this piece of work will build on that already completed and will expand this process to include all ages.

Analysis

4. Achievement against the key objectives within the Suicide Safer Community Strategy is reliant upon an engaged and supported multi-agency response.

4.1 For the purpose of this report because reducing rates of self-harm is identified as a defined objective within the Suicide Safer Community 2018-2023 Strategy, this section of the report will consider both topics within the remit of the strategy.

4.2 The creation of a clear reporting and governance structure where the newly forming York Suicide Safer Community Delivery Group will report into The Mental Health Partnership which in turn reports into the York Health and Wellbeing Board provides a multi-agency framework in which the objectives within the Suicide Safer Community 2018-2023 Strategy can be achieved. This will require full and appropriate engagement from the full range of key partner organisations across the city to achieve an effective city-wide, multi-agency response.

4.3 To achieve a true community level response to suicide prevention within our city, we will be required as a community to promote, lead on and support change in a range of ways: changes to culture, challenges to stigmatisation surrounding mental ill health and suicide prevention;

changes to how we assess risk, how able we are to identify early and respond to the signs of mental health distress and suicidal risk; the development of pathways into support that are accessible and responsive to the needs of people who require support; how we are able to support people to develop skills and ability to cope and recover from mental ill health.

4.4 Locally, there are a range of established and developing pieces of work that can and do contribute to the success of the suicide prevention strategy such as the Crisis Care Concordat; the Prevention Concordat; and Time To Change.

4.5 Particular areas of the strategy which might require particular focus in terms of supporting their achievement are identified below:

Training

4.6 The provision of a training programme to support awareness raising and effective responses to suicide risk currently has a capacity to train 300 people in SafeTalk during 2018–2019, and 150 people in ASIST over a two year period (2018–2020).

4.7 The achievement of this training programme is through funding from City of York Council Public Health Department and the Adult Safeguarding Board and is enabled primarily by the time and accredited trainer skills of a CYC employed Suicide Prevention Co-ordinator.

4.8 There are limitations in how much further the scope of this training can be offered as well as concerns about the future sustainability of this training offer post 2019. The provision of these courses is reliant upon partner agencies being able to provide free venues in which to run the training.

4.9 How able to support the achievement of an effective community level response to suicide prevention this relatively small amount of training capacity can achieve is a challenge.

Support for those affected by suicide

4.10 The provision of a service which supports those bereaved and affected by suicide is an objective within the suicide safer strategy.

4.11 Existing arrangements within York see the Major Incident Response Team (MIRT) offering support for those people bereaved by suicide. People affected by suicide are identified by colleagues in services such as North Yorkshire Police or the Coroners Office and referred into MIRT to receive support through a network of existing volunteers. The MIRT service has been instrumental in helping to set up a support group which links into a national network of support groups called Survivors of Bereavement by Suicide (SOBS) in York.

4.12 The provision of this 'postvention' suicide support by the MIRT team is not funded through commissioned arrangements to provide a dedicated service. This support is provided as a voluntary arrangement by the MIRT resource which we are lucky to benefit from but which carries with it risks of lack of accountability and sustainability that wouldn't be present if this were a formally commissioned service.

4.13 Options to consider how a locally relevant service might be funded in a multi-agency way which provides: postvention arrangements; supports broader suicide prevention priority areas; and is accountable and locally relevant is an area for development that carries resource implications beyond the scope of City of York Council.

4.14 Possible solutions would require scoping and an assessment of the resource implications upon a range of local stakeholders.

Multi-agency approach

4.15 The recent agreement for a reporting and governance structure into the Mental Health Partnership to achieve the Suicide Safer Community 2018-2013 Strategy demonstrates the commitment to and requirement for a multi-agency approach.
What this multi-agency approach means in terms of how each agency prioritises this agenda; allocation of resources; and support for the less tangible elements of change that are required in relation to cultural messages around wider concepts of mental health and wellbeing, are particular challenges.

4.16 Locally, there are already a range of multi-agency partnerships to support the mental health agenda, which the suicide prevention and self-harm agenda's clearly align to – such as the All-Age Mental Health Strategy and Crisis Care Concordat.

4.17 There are more recent programmes of work that may require supportive development to help achieve true multi-agency participation in: such as achievement against the recent Health & Wellbeing Board Commitment to sign up to a Public Health England proposal for a Prevention Concordat of which early identification and support, the removal of barriers to accessing support due to stigma are both key components – both of these areas are particular priorities within our suicide prevention approach and which require whole system change to help achieve.

4.18 A locally developing Time To Change hub which contributes to a growing social movement to challenge stigma and discrimination experienced by those with mental ill health is another example of a programme of work that acknowledges the importance of stigma and discrimination as barriers to accessing support and recovering from mental ill health.

4.19 Stigma, discrimination and prevention are all key themes within the mental health and wellbeing discussion and also specifically within suicide prevention. Achievement of change in relation to reducing the stigma associated with mental ill health, suicide and self-harm, is perhaps one of the more challenging elements of our strategic objectives.

4.20 In order to achieve against this, it requires a shared vision of how to affect change as a whole system and that suicide prevention is everybody's business is taken as a standpoint by all partners.

4.21 How services and support arrangements are commissioned, developed and informed; how services operate in effective collaboration with each other; how we engage residents to be able to support the principles of suicide prevention and cultural change in how we view mental health and wellbeing; and how we engage contribution from the full range of local leaders from community, voluntary, education, business, and statutory sectors to support this agenda are all important considerations for the achievement of our ambition.

Options

5. There are no specific options to choose between. A number of recommendations members may wish to give consideration to are detailed in section 9 of this report.

Council Plan

6. The prevention of suicide and the topic of self harm are both clearly identified as priority areas within the All-Age Mental Health Strategy and the work of the Mental Health Partnership.

6.1 Suicide Prevention and self-harm relate to The Council Plan priority of creating a prosperous city for all as we can identify inequalities in relation to increased risk of self-harm and suicide where deprivation exists.

6.2 Suicide prevention and self-harm relate to The Council Plan priority of focussing on frontline services where we can identify priority areas in relation to how effective services are able to respond to suicide risk and presentations of self-harm.

6.3 Suicide prevention and self-harm relate to The Council Plan priority of listening to residents as we can identify ways in which being better able to support community members who experience risk of suicide or who have experienced bereavement by suicide or self-harm is shown to carry stigmatisation.

7. **Implications**

Financial - There are no direct financial implications noted within this report.

Human Resources (HR) - There are no known Human Resources implications within this report

Equalities - There are no known Equalities implications within this report

Legal - There are no know Legal implications within this report

Crime and Disorder - There are no known Crime and Disorder implications within this report

Information Technology (IT) - There are no known Information Technology implications within this report

Property - There are no known Property implications within this report

Risk Management - There are no known risk implications within this report.

Recommendations

9. A range of recommendations are presented for scrutiny committee members to consider.

9.1 These are not being presented as recommendations that have been assessed based on choices between options but rather as potential ways in which scrutiny members may wish to consider in order to help support the progress of the suicide prevention agenda and the reduction of and response to self-harm within the City:

- Members are asked to consider whether funding into our suicide prevention training resource - which is currently from Public Health and Adult Safeguarding Board - is adequate to help achieve a community level, city-wide change in how we are able to reduce suicide.

Reason: *The provision of training at an adequate level to support change at a city-wide level is one which requires greater investment*

- Personal attendance at SafeTALK training by committee members

Reason: *Attendance at suicide prevention training on how to identify and respond to risk could raise awareness and understanding of the suicide prevention agenda and improve effectiveness as local community leaders.*

- A York Suicide Safer Community Delivery Group is currently being re-established. Members are asked to consider how they could help support the achievement of the objectives of this group

Reason: *Local involvement and support from members by attending the group could help influence and support community level responses to the prevention of suicide*

- Members are asked to consider how they might contribute to a developing communications plan to support the promotion of key suicide prevention messages; the suicide prevention agenda; and the challenge of stigma and discrimination for our residents

Reason: *Providing consistent and informed messages about suicide prevention - and more generally mental health - can help to challenge stigma, discrimination and help to support early identification and access to support*

- Members are asked to consider how City of York Council can visibly support suicide prevention and lead by example in ways that support the suicide prevention agenda. This might be by developing an organisational suicide prevention and response plan; by signing up to the employers pledge of the national Time To Change programme; or by incorporating a focus on mental health and wellbeing within a workplace wellness approach

Reason: *City of York Council should lead by example when it comes to supporting principles by which we ask other organisations to adhere to*

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Sharon Stoltz
Director of Public Health

Report Approved ✓ **Date** 01/11/18

Wards Affected: *List wards or tick box to indicate all* **All** ✓

Annexes

Annex 1: York Suicide Safer Community Strategy 2018 November draft
Annex 2: Self-harm-needs-assessment-2016
Annex 3: COY Self Harm and Suicidal Behaviour Oct 17

Abbreviations

ASSIST – Applied Suicide Intervention Skills Training
CAMHS - Adolescent Mental Health Service
CYC- City of York Council
JSNA- Joint Strategic Needs Assessment
MIRT Major Incident Response Team
SOBS - Survivors of Bereavement by Suicide

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York Suicide Safer Community Strategy

2018 - 2023

CITY OF YORK COUNCIL

Contents

"The true measure of any society can be found in how it treats its most vulnerable members."
Mahatma Gandhi

Foreword

Suicide is a serious social and public health issue. Every year too many York residents take their own life and many more people are deeply affected by the loss of a loved one, friend or colleague through suicide.

Yet suicide is largely preventable and can be reduced by concerted efforts of services and communities working together to tackle it. This is recognised by strategic leaders of statutory services in York. The City of York Joint Health and Well-being Board Strategy 2017-22 contains a stated objective to 'Ensure that York becomes a Suicide Safer City'.

To fully embrace this ambition we, as a community, as services and as individuals must make changes to some of our ways of working, attitudes and culture. We must be more ready to talk about suicide and to consider suicide prevention the responsibility of every one of us. This will undoubtedly involve some uncomfortable conversations, difficult decisions, some risks and the need to learn from mistakes. By preventing suicide we will reduce the human and economic costs which impact us all.

That's why it is so important that all services, organisations and individuals within our city respond to our collective call - our joint ambition - to make York a Suicide Safer Community.

Sharon Stoltz
Director of Public Health,
City of York

Introduction

In York around twenty five people take their own life every year - a shocking, tragic avoidable loss of human life which has far reaching consequences for those affected and society in general. Suicide remains a relatively rare event in comparison with leading causes of death and yet, as one of the most preventable, unnatural causes, it is responsible for a significant number of lives lost prematurely and, as a consequence, a high number of 'years of life lost'. Each individual death has a huge, often devastating affect on loved ones, friends, colleagues and the wider community.

Public Health England research shows that, on average, between six and twenty people are deeply affected by each suicide and that such loss can have a long term impact on their health and wellbeing, potentially placing them at heightened risk of later suicide themselves.

In November 2016 the York Health and Wellbeing Board considered the issue of suicide following the presentation of the York Five Year Suicide Audit report together with mortality data published by the Office for National Statistics for the years 2012-2015. The Yorkshire and Humber region currently has comparatively high rates of suicide and in recent years the City of York has experienced rates higher than most of its neighbouring local authorities and some of the highest in the country. Members expressed serious concern at the suicide rate in York and in particular over a series of deaths which had recently deeply affected the York student community.

The Board concluded that a strategic commitment and multi-agency response was needed in order to significantly reduce the incidence of suicide in York. Agreement was reached that the most effective way of achieving this would be through the Living Works' 'Suicide Safer Community' model.

The City of York Joint Health and Wellbeing Strategy 2017-2022 presents the Board's vision to improve the health of the population of York. A central theme of that strategy, 'Mental Health and Wellbeing,' contains the objective to 'Ensure that York becomes a Suicide Safer City'. This means that for the first time Suicide Prevention is a specific priority for the City of York.

Suicide and the causes of suicide are varied and complex and approaches to prevent it need to be multi-dimensional with links to many different agendas. These include; mental and physical health, economic deprivation and debt, substance misuse, employment and retirement, education, media and social media, housing, criminal justice, social isolation, family and relationship break-down and bereavement. On a wider perspective there are clear associations with issues of human rights, equality and diversity, safeguarding and community cohesion. At a population level long term reduction in suicide rates is only achievable through proactive, co-ordinated and collaborative activities which are on-going year on year. Suicide prevention is not a project or campaign, it is work which must continue through-out the short, medium and long term.

Suicide Safer Community designation is an award which must be earned, subject to independent scrutiny and verification rather than something which can be self proclaimed or declared by a locality, its leaders or partnerships. Few areas in the UK have this as a stated ambition and fewer still have plans which are so well developed to the point of seeking accreditation. In York, whilst there are many excellent services and initiatives which are directly and indirectly linked to suicide prevention- statutory, commissioned, private or voluntary- they are not currently linked or co-ordinated in ways which would clearly demonstrate 'synergy' or prioritisation of suicide prevention against other competing commitments across all sectors.

This strategy provides an overview of what a Suicide Safer Community is, what the work to achieve it involves and some of the challenges we face. It describes how York will develop the concept of Suicide Safer Communities whilst meeting the goals and objectives presented within the national suicide prevention strategy - to reduce suicide and improve support for people affected by suicide. The strategy will form the foundation of an accompanying multi-agency framework which will be the operational plan for local delivery. That is how we propose to deliver the actions and initiatives necessary to make our Suicide Safer Community ambition a reality. The journey, it could be argued in view of the potential benefits and what's at stake, is even more important than the destination.

How has this strategy been informed?

In producing this strategy we have considered:

- National research and best practice, particularly that highlighted in the national suicide prevention strategy for England (2012 and later updates)
- The Five Year Future View for Mental Health (2016)
- Future in Mind (2015)
- No Health without Mental Health (2011)
- The Living Works Suicide Safer Community model and its ten 'pillars'
- The National Confidential Enquiry into Homicide and Suicide by People with Mental Illness (2017)
- Guidance from Public Health England in relation to specific related topics such as suicide prevention planning, local partnership arrangements, response to emerging suicide clusters and support for people who are bereaved (2016-17)
- Findings from the York five year suicide audit (2010-14) and other relevant sources of national and local data
- Comments, ideas and suggestions from people who attended the North Yorkshire Mental Health and Suicide Prevention Lived Experience event in October 2016 and the York Suicide Prevention Conference in September 2017
- The views and expertise of a wide range of stakeholders including those who work within relevant fields and those who are themselves bereaved through suicide.

Suicide prevention is embedded within both the Joint Health and Wellbeing and Mental Health strategies for York and yet the complexity of suicide and broad scope of prevention activity necessitate strong links to various other strategies, partnerships and policies which relate to the general health and wellbeing of our residents and workforce. These include:

- Joint Strategic Needs Assessments
- Sustainability and Transformational Partnerships (NHS) action plans
- Local Crisis Care Concordat action plans
- Local Prevention Concordat action plans
- CCG Commissioning Intentions
- Local transformation plans for children and young people's mental health and wellbeing
- Commissioning of alcohol and substance misuse services

What is Suicide Safer Community designation?

The 'Suicide Safer Community' concept created by The LivingWorks Foundation in Canada is an internationally recognised model used by many localities across the world to structure, focus and drive suicide prevention activity based around ten pillars of action: **https://www.livingworks.net/community/suicide-safer-communities/**

> Living Works says:
> **"The Suicide-Safer Communities designation honors communities that have implemented concerted, strategic approaches to suicide prevention. The ten pillars in this designation reflect the core elements of suicide prevention strategies around the world. The designation celebrates and acknowledges those communities who have made significant progress in reaching their suicide-safer goals, and helps others understand what strategic steps they can take to prevent suicide on a community level".**

At the heart of the Suicide Safer Communities concept are some fundamental principles which are the cornerstone of Living Works' four suicide prevention workshops - Suicide Talk, safeTALK, ASIST, and Suicide to Hope. In order to embrace the Suicide Safer Communities idea it is important that we collectively endorse these assumptions and build our attitudes and activities around them:

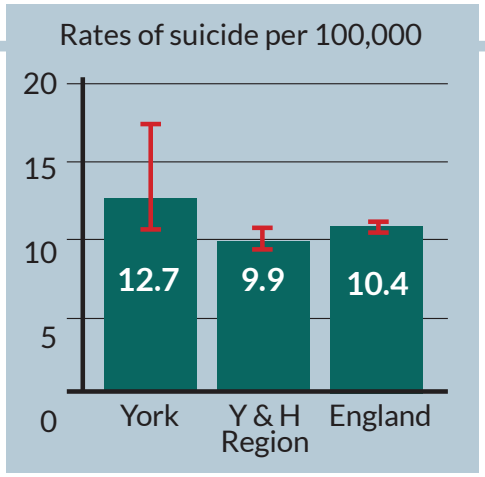
- Suicide prevention is not the sole responsibility of mental health services, General Practice or other clinically trained professionals. Anyone can potentially encounter someone at risk of suicide and so everyone has a part to play in preventing it.
- Most people who take their own life do not actually want to die. Instead they wish to end the pain which they are experiencing at that particular moment in time. Whilst part of them sees dying as their only choice there is also a part of them that wants to live. People who are close to suicide often seek reasons to go on living - sometimes a tiny glimpse of hope, even a kind word from a stranger can make all the difference.
- The majority of people who die by suicide give some kind of indication of their intent to someone in the days, weeks or months beforehand. Sometimes these are obvious - serious self harm or suicide attempts, talking about their intent or plan or uncharacteristic changes in behaviour or attitude. Often though these signs are subtle and easily missed or dismissed by family, friends and professionals.
- Talking about suicide and asking about suicidal thoughts in informed and compassionate ways can and does save lives if the person to whom a disclosure is made is vigilant and able to make or arrange a suicide intervention. Sometimes people reach a point of suicide only once in their lives. Others may have regular thoughts of ending their lives. If they are asked about their intention at the critical time and are supported to make the decision to live then suicide can be prevented or deferred indefinitely.

The causes of suicide

Suicide is a very private, individual act usually associated with extreme and unbearable feelings of hopelessness, despair, loss, guilt or pain. Many people assume that only people who have a diagnosed mental illness die by suicide. Whilst there is a strong link to mental ill-health, short term or long term, many people who take their own life are not in touch with any services and are not known to mental health professionals. Mental illness, particularly depression and anxiety in their various forms can go unrecognised and undiagnosed, and such conditions which are untreated or under-treated are frequently connected with suicide. It is important to recognise that any one of us can experience mental ill-health and suicidal thoughts as we face various life events and stresses which are part of our ever more complicated and pressured lives and prompt, appropriate treatment and management can and does save lives.

Whilst the causes of suicide are wide-ranging and suicide is often a result of a combination of different issues rather than a single factor, there are some common themes. National and International research identifies which issues are most prevalent and which groups are most at risk. National data and research very much reflects the local picture of suicide captured in the York Suicide audit report which provides a clear indication of higher risk groups and which life-style factors were most common in respect of completed suicides in the city over the five year period 2010-14. This information is helpful when looking at reducing suicide on a population level but it is vitally important not to dismiss someone potentially at risk of suicide simply because they don't fit a particular profile.

Background



A rising trend in rates over the last ten years.

Higher rates of self harm in York for adults and young people

York suicide audit 2010-2014 (60 deaths)

Over-representation from people living in deprived areas. Almost **60%** of people dying by suicide lived in the **most deprived 40% of York**.

83% were male. Middle aged men at highest risk

73% were single, divorced or separated. 44% lived alone

40% had a history of self harm, 25% had attempted suicide previously

63% had seen their GP in the previous year

47% had a history of substance misuse and 37% had consumed alcohol prior to their death

Key factors identified were mental health (diagnosed or undiagnosed); loneliness and isolation and family/ relationship problems and breakdowns.

Trauma/bereavement were also 'triggers'. 62% had contact with the criminal justice system in last year as victims, cause for concern, witness, offenders, suspects etc.

85% had contact with at least one agency/organisation in the previous year

48% had physical or sensory health problems at the time of death

Four out of 28 with substance misuse issues were known to treatment services

Post audit...

Changes in at risk groups - females now account for **40%** in York compared with **8%** a decade ago

Groups who did not show up in the audit but we know are at raised risk e.g. People who are LGBT, male travellers, service veterans, mothers in the perinatal period

Eight student deaths since the audit

Risk factors for YPs in York i.e. high self-harm & mental health admissions

Vision and central theme

Our vision is to develop a community which has sustainable, co-ordinated and collaborative approaches to suicide awareness, prevention, intervention, post-intervention and postvention. A supportive, connected and compassionate city where no one feels so distressed, so hopeless, so isolated or so trapped by events or circumstances that they believe suicide to be their only choice.

Our central theme is to develop a 'Suicide Safer Community' to reduce suicide in the City of York. Reducing rates of suicide, initially to below national and regional average rates and then further reducing it year on year is a core aim of Suicide Safer Communities and of this strategy. By doing so we can avoid unnecessary loss of life and unimaginable distress being caused to those who would otherwise become bereaved. Preventing suicide however is not the only goal. By embracing this concept we have an opportunity for our city and our residents to benefit in so many other positive ways.

We know that incidents of suicide in York, despite comparatively high rates are, thankfully, rare. However the causes and catalysts for suicide are not rare and often result in immeasurable, enduring damage to the lives of individuals in ways which are not actually related to suicide. Those life events and stresses which lead some to suicide can for many other people lead instead to different harmful effects or behaviour, the consequences of which seriously undermine their health, quality of life and general contribution and, sometimes cause significant damage to others or to society. Examples of these include:

- long term deterioration of mental health
- reduced personal resilience and ability to contribute and thrive
- withdrawal from work, education or social networks
- drug and alcohol misuse
- self-harm
- increased risk taking behaviour
- criminal activity including domestic violence and other forms of abuse
- intolerance, prejudice, discrimination, extremism.

By tackling many of the issues that sometimes lead to suicide we can at the same time address the risks and triggers which lead to other harmful outcomes generally related to adversity and disadvantage. This will result in greater social cohesion, improved community links and availability of support, more open caring conversations and a collective desire for people to look after each other. We will seek to address these issues through collaborative, partnership working – sharing appropriate information between statutory agencies and other services and ensuring that there is effective, joined up working to identify and support people at risk.

We will identify gaps in services and work together with the voluntary sector, private industry, our communities and people who use services to cover those gaps through asset based and innovative approaches.

We will raise awareness of the impact of suicide and of the prevalence of suicidal thoughts. We will endeavour to change attitudes and reduce stigma by talking more openly about suicide and about mental health so that more people are encouraged to seek help when they need it. We will do all we possibly can to reduce feelings of hopelessness, isolation and distress caused by adverse lifestyle factors and so called wider determinants of health such as poverty and deprivation, housing, debt, insecurity of employment and inequality of opportunity. We will do what we can to support people during the most difficult, challenging times of their lives following bereavement, business failure, redundancy or loss of employment, family or relationship breakdown, release from prison or diagnosis of long-term, serious or terminal illness.

We will be better at identifying who those people are by engaging specific groups, recognising differing risks and by putting people in touch with services which can offer expertise, advice and support.

We recognise that building a genuine Suicide Safer Community is a long term goal which requires wholesale culture change towards more caring, supportive approaches in every aspect of our day to day lives. Suicide Safer Communities are compassionate, understanding, accepting, resilient and optimistic communities where everyone's life matters. That is our ambition for York.

Key objectives and outcomes

The following nine areas of action provide the foundation for how we will deliver the central theme of this strategy which is to make York a Suicide Safer Community. Numbers 1-7 are taken directly from the national suicide prevention strategy whilst 8 and 9 are considered necessary components of local delivery of this agenda. Each of these should be regarded as 'long term' objectives and therefore contain short and medium term priorities to demonstrate milestones and progress and on-going or recommended work-streams which need to synergise in order to make Suicide Safer Community status a reality in our city.

Area for action 1

Reducing the risk of suicide in high risk groups

Achieving a reduction in suicide at a population level involves reaching more people who are at raised risk of taking their own lives, be they members of a specific group within the community, people who have particular life-styles or who have experienced particular life stresses which reduce 'protective' factors and increase' risk factors'. Responsibility for producing an action plan and delivering on key objectives of this strategy will rest with the multi-agency York Suicide Safer Community Delivery Group. This will report to and be held to account by the Mental Health Partnership and Health and Well Being Board.

What we know:
Based upon national evidence and local intelligence the groups identified as being at highest risk of suicide in York include men, particularly those aged between 40-55 years old. Our audit of suicides between 2010 and 2014 showed that 83% of suicides occurred in men. The average age of deaths of those men was 41.9 years. Other groups at recognised higher risk are many and varied and include people with untreated mental ill-health, people who have made a previous attempt on their life, people of all ages who self harm, people who have been recently discharged from mental health services and people who have drug and alcohol issues who are not in contact with substance misuse services.

Whilst suicide by children and young people is very rare they are considered at higher risk as a result of vulnerability associated with their age and other adverse factors which may be prevalent in their lives such as abuse, bullying, academic pressure, social media and unsettling periods of transition. There is increasing concern at national level of the risk to higher education students and York has experienced higher numbers of student deaths in recent years than during any previous time period. Our ongoing work will consider what we know about other groups at higher risk and develop a work plan to address this.

In order to reduce the risk of suicide within identified groups we will:

- Use information from the five year audit and more recent data to identify and engage those groups at recognised higher risk
- Explore innovative, non traditional ways of engaging such groups in settings where we are able to raise awareness, challenge unhelpful attitudes and culture and encourage seeking of support
- Make use of evidence based national guidance and best practice used successfully in other areas of the country
- Deliver suicide alert and suicide intervention training appropriate to the audience including clinical and non-clinical staff, the general workforce and across our communities
- Ensure that a more joined up approach is taken to tackling the wider determinants of health such as housing, employment, social isolation and deprivation whilst highlighting risks associated with bereavement, relationship breakdown, redundancy, trauma, physical and sexual abuse and the consequences of arrest, prosecution or imprisonment.

Area for action 2

Tailoring approaches to improve mental health in specific groups

What we know:
Around 52% of suicides reviewed in the York audit were by people who had received some form of psychiatric treatment within the previous twelve months having been in touch with their GP or mental health services during that time. Many of those people though had withdrawn from treatment and of those people who had no contact with services it is evident that a large proportion had a current mental health condition which was undiagnosed and as a result were not receiving any treatment from health services.

National research suggests that as many as 90% of people who take their own life have, at the time, a mental health condition –albeit often undiagnosed and untreated. Depression (including postnatal depression) is one of the most important risk factors for suicide and undiagnosed or untreated depression can heighten that risk. Primary care services have a key role in identifying and treating mental health problems as well as assessing an individual's suicide risk. People with severe mental illness are at higher risk of suicide, both while on inpatient units and in the community.

The risk to inpatients is mitigated by close supervision and support from staff whilst those recently discharged from hospital and those who refuse treatment are at heightened risk.

To tailor approaches for specific groups we will:

- Review and develop pathways for Primary Care in relation to suicidal thoughts and self harm. Ensure that referrals to secondary care mental health services are appropriate to the need and that other referral options are explored Develop and influence partnership working around dual diagnosis issues
- Promote and support the principle of Mental Health Parity of Esteem
- Support and influence the work of the North Yorkshire Crisis Care Concordat to improve support for those in crisis
- Develop Prevention Concordat approaches to promote positive health and well-being and encourage self-help activities which reduce the likelihood of people developing more serious mental ill-health
- Encourage and ensure compliance with national best practice guidance around suicide prevention within mental health service provision.

Area for action 3

Reducing access to means of suicide

What we know:
One of the most effective ways to prevent suicide is to reduce access to high lethality means of suicide. This is because people sometimes take their own life on impulse and if the means are not readily available the suicidal impulse may pass. The suicide audit did not identify any locations or sites of high frequency and most suicides in York take place in the home or on other private premises. There are opportunities to reduce access to the means in relation to most common methods of suicide and we will work with relevant partners to highlight these and take appropriate action

To reduce access to the means of suicide we will:

- Further develop suicide surveillance processes to include suicide attempts to identify and respond to patterns and trends.
- Support the work of Network Rail, Samaritans and British Transport Police to reduce risks on the railway network and work with Highways England to extend best practice to our road network
- Identify opportunities for appropriate signage at emerging high frequency or risk locations to encourage help-seeking and 3rd party intervention.
- Explore opportunities to reduce and mitigate risks associated with access to, prescribing, storage and retention of medications.
- Ensure that suicide prevention work is linked to the alcohol strategy and embedded within the role and responsibilities of commissioned services.
- Ensure that conversations with people who have suicidal thoughts include discussions about intended plans and means. If such information is disclosed then agreement can then be sought to devise a co-produced safety plan with that person to reduce or restrict access to identified means.

Area for action 4

Providing better information and support to those bereaved or affected by suicide

What we know:
Families and friends bereaved by suicide are at an increased risk of mental health and emotional problems and may be at higher risk of suicide themselves. There are many people in York who have been bereaved or deeply affected by suicide as a result of recent events or loss of someone close at some other time in their lives. We know that such people encounter stigma –ill-informed, judgmental attitudes which make it even more difficult for them to talk about their experiences. We also know that people bereaved through suicide often feel most understood, most supported by others who have had similar experiences, who are themselves bereaved through suicide.

To provide better information and support to those affected by suicide we will:

- Improve awareness of the impact of and risks associated with suicide bereavement within Primary Care
- Encourage outreach with people recently bereaved through suicide
- Raise awareness of the significance of anniversaries and birthdays and increased risks presented around those times
- Consider availability and profile of bespoke support for children and young people who are bereaved through suicide and develop service provision to address unmet needs in the short and medium term
- Ensure that GPs are familiar with the Help is at Hand Booklet and the Major Incident Response Team (MIRT) postvention service
- Further develop and raise awareness of the suicide postvention services offered by the MIRT and by York Samaritans and the Facing the Future initiative offered by Cruse/Samaritans
- Develop a Survivors of Bereavement by Suicide (SOBS) peer support group in York
- Hold an annual suicide prevention conference and service of reflection for people bereaved by suicide.

Area for action 5

Supporting the media in delivering sensitive approaches to suicide and suicidal behaviour

What we know:
The media has a significant influence on behaviour and attitudes. There is compelling evidence that media reporting and insensitive portrayal of suicide can lead to copycat behaviour, especially among young people and those already at risk. It can also cause additional distress to those people bereaved or deeply affected by suicide as a result of inappropriate use of language or speculative reporting. The media and social media can play a positive part in reducing suicide if messages are supportive and optimistic, raise awareness in positive ways and generally encourage conversations and help-seeking.

To support the media in delivering a sensitive approach to suicide and suicidal behaviour we will:

- Engage with local media to ensure adherence to Samaritans guidance and delivery of positive help-seeking and health and well-being messages
- Monitor and review media reporting in relation to specific incidents of suspected suicide and more general commentary around suicide, mental health and crisis care
- Raise awareness of the risks presented by inappropriate social media content and potential harm to the general emotional wellbeing of children and young people arising from excessive, un-moderated access to social media
- Develop a communications plan for the delivery of reports, messages, updates and appeals to ensure that the Suicide Safer Community brand is recognised and visible
- Ensure that stakeholders' press departments are aware of best practice guidance and that press releases following suspected suicides or coroners conclusions are jointly agreed between partners
- Use media opportunities to raise awareness of and contribution to York's ambition to be a Suicide Safer Community

Area for action 6

Supporting research, data collection and monitoring

What we know:
Reliable, timely and accurate suicide statistics and the analysis of the circumstances surrounding each suicide in York can highlight trends, identify key risk factors for suicide and inform future partnership activity. Research and evaluation enhance our understanding of what works in suicide prevention locally. Mechanisms for monitoring progress are essential for the successful delivery of this strategy.

In order to support research, data collection and monitoring we will:

- Conduct regular audits of information relating to local deaths by suicide including coroner's files.
- Conduct post inquest reviews of student deaths determined as suicide or of undetermined intent
- Further develop an early alert process to prompt sharing of appropriate information by the police and coroner's service, referral to support services and multi-agency response
- Maintain and support the Real-time Surveillance spread-sheet and protocol ensuring timely response to emerging trends and extend this to include incidents of attempted suicide
- Encourage a multi-agency approach to serious incident reviews and lessons learned procedures, ensuring that resulting information is disseminated appropriately.

Area for action 7

Reducing rates of self-harm

What we know:
Self harm and self-injury can take many different forms, usually unrelated to suicide, and can in fact be a way for people to alleviate feelings of severe emotional distress. It's not possible to know the full extent of self-harm in society because much of it is hidden and a relatively small proportion of episodes result in hospital treatment or contact with other medical services.

Whilst self-harm can form part of coping mechanisms, it can for some people become more and more severe and sometimes people die as a result of self harm episodes when it is evident that there was no intent take their life. Research shows that people who self-harm are at much greater risk of suicide, particularly within the following twelve months and it is now widely recognised as the biggest indicator of suicide risk.

The underlying causes of emotional distress which lead to self-harm can lead to or aggravate other life-stresses and result in suicide. We know that there is a general lack of understanding of self harm and some unhelpful myths and attitudes which only serve to increase the stigma faced by people who self-harm, discouraging them from disclosing their distress or seeking help.

Around 40% of people who died by suicide in York between 2010-14 had a history of self-harm.

To reduce the rates of self harm we will:

- Encourage a culture where self harm is more openly discussed in non-judgmental, helpful ways to encourage help seeking and reduce stigma
- the 'Self-harm and suicidal behaviour; working with children and young people' document' produced by York's Strategic Partnership for Emotional & Mental Health (children and young people) is utilised and updated to reflect best practice approaches.
- Progress evidence based training and awareness raising in relation to self harm and referral options and responsibilities. Ensure advice and guidance is available for non-clinical, front-line personnel who are in contact with people who may be self harming
- Develop clear pathways that adhere to NICE guidance in relation to self-harm and make sure they are embedded and universally recognised by relevant services
- Ensure that psycho-social assessments are offered to anyone who presents in relation to self-harm and that co-produced safety plans are considered where ever possible

Area for Action 8
Training and awareness raising

What we know:
Dedicated suicide prevention training, particularly that associated with Living Works' ASIST and safeTALK programmes, encourage more open and informed conversations about suicide and give people the confidence to ask someone if they have suicidal thoughts and to intervene where appropriate.

These workshops are suitable for people who may have suicidal thoughts themselves, serving to increase self-awareness and encourage them to tell someone or to seek help when they need it.

In order to develop the training offer and raise awareness we will:

- Continue to deliver Applied Suicide Intervention Skills Training (ASIST) and safeTALK training to the workforce and communities prioritising those roles likely to include contact with people at raised risk of suicide
- Deliver self –harm training bespoke to the needs of services/organizations
- Encourage delivery Mental Health First Aid training as part of workforce development and staff health and well-being policies
- Offer suicide bereavement training (PABBS) for appropriate services
- Explore funding sources across statutory, private and voluntary sectors to encourage relevant training programmes within all organisations to promote well-being and raise awareness of suicide risk
- Support Lived Experience events and presentations to ensure the voices of those who have experienced mental ill-health, suicidal thoughts or bereavement are heard and influence decision makers and commissioners
- Evaluate training programmes to measure learning outcomes and impact
- Develop a network/community of ASIST trained people to ensure that perishable skills are retained and refreshed
- Link to and influence other training and agendas for example The Armed Forces Covenant and York Human Rights City Declaration

Area for action 9

Preparedness and post incident management

What we know:
Many organisations that have not experienced or been touched by suicide are not inclined to consider the possibility of one of their staff or clients taking their own life or the impact on their workforce.

When it does happen suicide devastates communities and organisations and leaders and managers typically find themselves wholly unprepared, having to respond to the needs of a wide range of people whilst under extreme emotional and logistical pressure. We believe that it's important for organisations and institutions to prepare for an eventuality - one which they hope will never happen- which will help to mitigate the impact and further risk if an incident of suspected suicide does occur.

We will:

- Develop and share a local suicide cluster response protocol informed by national guidance and experience from the series of student deaths in York
- Ensure that suicide prevention and support information is available, accessible, credible and marketed
- Develop multi-agency post incident, pre-inquest investigation and post inquest lessons learned arrangements
- Monitor and respond to national guidance and updates from bodies such as National Institute of Clinical and Care Excellence (NICE) , Samaritans and The National Suicide Prevention Alliance
- Encourage the inclusion of suicide prevention within organisations' health and well-being plans and mental health strategies
- Encourage preparation of response plans for use in the event of a suspected suicide within schools and colleges, based on guidance and support from Samaritans and Papyrus.

“Too often we underestimate the power of a touch, a smile, a kind word, a listening ear, an honest compliment, or the smallest act of caring, all of which have the potential to turn a life around.”

Leo Buscaglia

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CITY OF YORK COUNCIL

Self-harm: local identification of needs

City of York Council

CONTENTS:

EXECUTIVE SUMMARY

Self-harm is reported to be a growing concern and issue locally. York does have slightly higher rates of hospital admissions due to self-harm than England average rates and anecdotal and audit information from a range of sources identifies growing concerns about increases in self-harm.

There is a current gap in the availability of comprehensive and robust data to be able to clearly identify the full scope of the issue. There are inconsistent ways of recording, reporting and sharing self-harm related information about risk and prevalence where an incident does not result in a hospital admission. Where self-harming behaviour does result in a hospital admission, there is a good availability of local data but this does not provide a full picture about the scope of self-harm.

A range of services and staff groups identify self-harm as a concern but information about the prevalence of this behaviour is not consistently collected or shared between services.

There is a lack of readily available advice and information for people to access about self-harm, how to identify when self-harming behaviour may be happening, what to do and how to support someone who is self-harming.

There is a reported lack of clear referral options for people who are known to be self-harming. Threshold criteria for access to mental health support services for people who are self harming but have no diagnosed mental health conditions are reported to be too high for people to be eligible to access. However, it should be noted that local child and adolescent mental health services are providing a good level of support to those young people who are accessing hospital services in relation to self-harm. There is also a joint pilot scheme to provide more support into the York Hospital Emergency Department (ED) in order to be better able to support people with mental health needs who are not admitted to hospital. This includes supporting people who are presenting to the ED with self-harm injuries.

There still exists a stigma around self-harm and the local health and social care system might benefit from a focus on training key staffing groups to be able to better support people who are self-harming. By supporting staff to be able to respond effectively to someone who is self-harming, it may make it easier for people to ask for help around self-harm and mental health support needs.

From this paper, there are four areas recommended for local consideration:

- To strengthen the identification and recording of self-harm related problems that do not result in a hospital admission. This will establish a baseline measurement of the extent of the issue and help raise the focus on the importance of accurately being able to identify self-harming behaviour. Without being able to accurately identify how much self-harm is happening it is not possible to demonstrate a suitable response to it.

- To develop and enhance a local offer of information, advice and training to key staff groups and people most at risk of self-harm. This will reduce barriers to people who self-harm seeking help and improve the ability of staff to be able to respond to self-harming behaviour and risks effectively.

- To be able to offer evidence based interventions that are effective in reducing self-harming behaviour and clear referral routes into this support. This would also contribute to removing barriers for people to ask for help.

- To seek assurance that appropriate and adequate pathways exist which allow people who self-harm to receive support. This would include clarity that; self-harming behaviour among adults is assessed and risk assessed by service providers; there are clear pathways into support where self-harming behaviour is identified which should include consideration of referral processes for adults and children from Emergency Department and referral from schools into CAMHS.

INTRODUCTION

Self-harm can be quite difficult to define. There is not one wholly accepted definition but perhaps the most commonly accepted is the NICE (2011) definition:

> Any act of self-poisoning or self-injury carried out by an individual irrespective of motivation.

This definition is stated to exclude harm from excessive consumption of alcohol or recreational drugs, or from starvation through anorexia nervosa, or accidental harm to oneself. However, these sorts of risk taking behaviours are often associated with self-harm. Behaviours such as substance misuse and eating disorders, dangerous driving, dangerous sports, sexual risk taking and self-neglect can be referred to as instances of indirect self harm.

For the purposes of this report the NICE definition as above will be used and the use of self-harm related information will predominantly draw on instances of direct self-harm rather than a wider definition which would include a range of risky behaviours.

In terms of how people self-harm, the most common form is reported to be cutting but there are a range of other ways in which people self-harm. Locally, the cause of admission to hospital in relation to self-harm is overwhelmingly through poisoning by paracetamol. Across the NHS Vale of York Clinical Commissioning Group area, there were 659 admissions to hospital related to self-harm between April 2014 – March 2015. Of these, only 19 were recorded as open wounds i.e. 'cutting' and 581 were related to poisoning – the most common substance used to self-harm through poisoning was Paracetamol.

Some of the other ways to self-harm might include:

- cutting;
- biting self;
- burning, scalding, branding;
- picking at skin, reopening old wounds;
- breaking bones, punching;

- hair pulling;
- head banging;
- ingesting objects or toxic substances;
- Overdosing with a medicine.

Mental Health Foundation (2006).

Self-harm is not the same as suicide or attempted suicide, it is generally used as a way of coping with emotional distress and the majority of people who self-harm do so with no intention towards suicide.

Whilst self-harming behaviour is predominantly a coping strategy which carries with it low immediate risk for suicide, it is not completely separate to suicide. A range of research identifies that future risk of suicide is increased by between 50 – 100 times because of self-harming behaviour (Royal College of Psychiatrists, 2010). In relation specifically to young people aged under 20 years old, 54% of death by suicide between January 2014 and April 2015 were in young people who had previously self-harmed (Healthcare Quality Improvement Partnership, 2016).

An increased level of immediate risk is identified for those aged over 65 who self-harm where the risk of further self-harm and suicide is substantially higher than in other age groups. All acts of self-harm in people older than 65 years of age should be regarded as evidence of suicidal intent until proven otherwise because the number of people in this age range who go on to complete suicide is much higher than in younger adults (NICE, 2011).

For some, self-harming behaviour may only last for a short period of time where for others it might develop into a long-term coping strategy. Some people may stop self-harming but return to this behaviour at times of distress. It is often a secretive and hidden behaviour. This can make it difficult to identify and is not something that can always be changed easily. Even for those people who are receiving support from services, a recovery process can take a long time, particularly where self-harming behaviour has become a normal way of coping for that individual.

A recovery process from self-harm requires finding new coping strategies or using distraction techniques when a person has the urge to

self-harm. Different people find that different techniques work with varying levels of success and these may even vary in how well they work for a person depending on their mood or the situation they are in at that time. Finding the most useful alternative techniques takes time but trying different methods does work to find the most suitable for that person (Mental Health Foundation, 2006).

The reasons given by people who self-harm for their self-harm are varied but the most common is because of emotional distress:

- self-harm temporarily relieves intense feelings, pressure or anxiety;
- self-harm provides a sense of being real, being alive - of feeling something other than emotional numbness;
- harming oneself is a way to externalise emotional internal pain - to feel pain on the outside instead of the inside;
- self-harm is a way to control and manage pain - unlike the pain experienced through physical or sexual abuse;
- self-harm is self-soothing behaviour for someone who does not have other means to calm intense emotions;
- self-loathing - some people who self-harm are punishing themselves for having strong feelings (which they were usually not allowed to express as children), or for a sense that somehow they are bad and undeserving (for example, an outgrowth of abuse and a belief that it was deserved);
- self-harm followed by tending to wounds is a way to be self-nurturing, for someone who never was shown by an adult to express self-care;
- harming oneself can be a way to draw attention to the need for help, to ask for assistance in an indirect way;
- on rare occasions self-harm is used to manipulate others: make other people feel guilty or bad, make them care, or make them go away;
- self-harm can be influenced by alcohol and drug misuse.

NHS Tayside (2011)

Self-harm is an expression of personal distress, not an illness, and there are many varied reasons for a person to harm him or herself (NICE,

2011). A range of factors may cause a person to start self-harming and these might include: family problems; feeling stressed; relationship problems; exam or school work pressure; low self-esteem; bereavement; loneliness and isolation; feelings of guilt; bullying; difficulties associated with sexuality; feelings of rejection; mental health issues; reaction to trauma or abuse; peer pressure; poor body image; substance misuse (drugs and alcohol). There may be a range of other reasons that lead someone to self-harm and these reasons may differ from person to person or be a combination of several different reasons.

Groups at risk

Self-harming is not restricted to a particular group. People of different ages and gender might self-harm and because much self-harming behaviour goes unidentified, due to its secretive nature and its use as a way of coping, it is difficult to identify a clear picture of how often it happens. However, self-harm is known to be more common in younger people than older people and more common in women than men.

The UK has one of the highest self-harm rates in Europe, reported at about 400 per 100,000 people (Royal College of Psychiatrists, 2010).

The reported rate of people admitted to hospital as a direct result of self-harm is identified to be lower than this estimate and in 2013, was 203 per 100,000 people. This figure only reports people who are admitted to hospital and does not account for those who do not seek medical help for wounds, who manage their own wounds from self-harm or do seek medical help but are not admitted to hospital e.g. in an Emergency Department (ED) setting that does not result in a hospital admission.

Because of the secretive nature of self-harming behaviour and stigma associated with self-harm, much goes unreported and the actual rates of presentation to hospital for treatment are likely to represent only a proportion of self-harming behaviour. It is difficult to accurately identify how much goes unreported.

There is not a consistent way that known self-harming behaviour that does not result in a hospital admission is recorded. Where self-harming behaviour might be known about by a range of support services such as mental health support services or schools, there is no standardised reporting process to identify how many people are affected. Just over 40% of young people who died by suicide during 2014 – 2015 were not known to services and had not expressed ideas of suicide; however, self-harm is known to be a common risk factor (Healthcare Quality Improvement Partnership, 2016). This makes it particularly pertinent to consider how able young people feel to access support when problems exist which make them vulnerable to risk of suicide, and what responses will work best to reduce that risk.

Anecdotally, services report increasing concerns about the amount of young people engaging in self-harming behaviour but it is very difficult to clearly identify how many people might be affected. The one clear measure that is available, hospital admission data, is an under representation of the true level of self-harming behaviour that takes place.

Local self-harm data

Public Health Outcome Framework data published by Public Health England shows that between 2010–2013, York is reported to have slightly higher rates of hospital admissions for self-harm in young people aged 10 – 24 than the England rate. This equates to 368 admitted to hospital per 100,000 people compared to 352 per 100,000 people across England.

Across all age groups for the same period, the rate is still higher than the England average. It is 215 per 100,000 people in York compared to 203 across England.

In North Yorkshire for the same time period, the rate for admission in 10-24 year olds is lower than the England average at 310 per 100,000 people.

In North Yorkshire across all age groups for the same time period, this rate is also lower than the England average at 173 per 100,000 people compared to the England rate of 203.

This shows that self-harm cases presenting to hospitals are higher in York than the England average rate and that the rate of hospital admissions because of self-harm is higher in people aged 10-24 than in the rest of the population.

Survey information reports that among 15-16 year olds, over 10% of girls and 3% of boys reported self-harming in the previous 12 months (NICE, 2011).

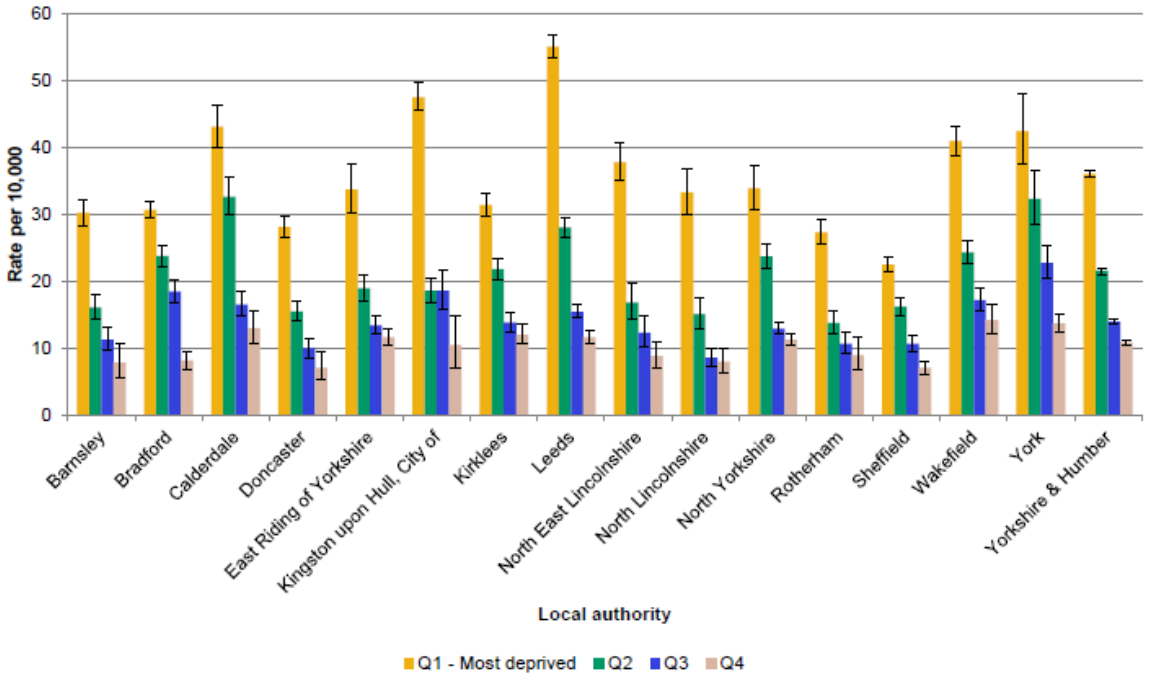
There are groups of people who are identified as being most at risk of self-harming behaviour. These are:

- adolescent females;
- young people in residential care;
- lesbian, gay and bisexual and transgender people;
- women of South-Asian ethnicity;
- prisoners;
- asylum seekers;
- military veterans;
- children and young people in isolated rural settings;
- children and young people who have a friend who self-harms;
- groups of young people in some sub-cultures who self-harm;
- children and young people who have experienced physical, emotional or sexual abuse during childhood;
- people living in financial deprivation or being unemployed
- people who misuse substances
- people who live in areas that are socially fragmented and disconnected
- people who experience adverse life events
- people who have existing mental ill-health problems and / or previous suicide attempts

NHS Tayside (2011); Royal College of Psychiatrists (2010); NHS Health Scotland (2014)

Increased levels of self-harm related admissions are linked to living in areas of deprivation. The graph below highlights how emergency self-harm admission rates are higher in areas of deprivation across all local authority areas in the Yorkshire and Humber region.

Emergency self-harm admission rates for all persons per 10,000 population by deprivation quartiles, 2010/11 - 2012/13



Source: Public Health England: Self-harm and suicide

Local hospital data for the period 2010–2013 for admission because of self-harm has been analysed to identify which wards that people who have been admitted to hospital because of self-harming live in.

This identifies a general trend of higher levels of self-harm related admissions among people who live in wards that have higher levels of deprivation (e.g. Westfield, Guildhall), or have higher proportions of students and people of Asian ethnicity (e.g. Heworth) than the local authority area average.

Three of the five most deprived wards in York have rates of hospital admission for self-harm those are among the 5 highest by ward: Westfield, Clifton and Heworth.

ANNEX 2

Hospital admissions for self-harm by Local Authority ward area

Admissions for self-harm	Population mid 2013 estimates	% Admissions per population	Ward Name	IMD 2015 (high score = more deprived)
131	13,809	0.95%	Westfield	25.8
94	9,626	0.98%	Guildhall	21.66
94	14,134	0.67%	Clifton	21.01
118	14,217	0.83%	Heworth	16.58
82	12,504	0.66%	Micklegate	15.64
98	11,073	0.89%	Hull Road	14.29
77	13,036	0.59%	Holgate	14.08
46	8,720	0.53%	Acomb	12.95
99	12,206	0.81%	Huntington and New Earswick	12.39
63	11,438	0.55%	Dringhouses and Woodthorpe	9.64
108	10,125	1.07%	Fishergate	9.14
10	3,733	0.27%	Osbaldwick	8.66
44	8,191	0.54%	Strensall	7.85
49	13,375	0.37%	Skelton, Rawcliffe and Clifton Without	7.03
8	2,820	0.28%	Fulford	6.76
9	3,603	0.25%	Heworth Without	5.46
40	5,497	0.73%	Heslington	5.42
12	3,991	0.30%	Bishopthorpe	5.4
6	3,623	0.17%	Derwent	5.08
42	11,972	0.35%	Haxby and Wigginton	4.76
*	4,214	n/a	Wheldrake	4.6
40	10,526	0.38%	Rural West York	4.57

Source: Public Health England; Hospital Episode Statistics; Office for National Statistics IMD

The wards used in this data analysis are old ward profile areas that have since been replaced but because of the data parameters of this data, it has not been possible to use the new ward boundaries.

Locally, hospital admissions among 10-24 year olds can be seen to have fluctuated year by year but that the most recent figures show an increase from 6 years earlier and are at the highest level in this 6 full year period.

These figures clearly show that self-harm admissions for girls and women are higher than in boys and men and are approximately 3 times as high. This reflects national trends in gender differences of self-harm.

Young people aged 10 to 24 years resident in York who were admitted to hospital as a result of self-harm

	Gender		
Financial year	Male	Female	Total
2007/08	43	125	168
2008/09	59	131	190
2009/10	61	132	193
2010/11	41	109	150
2011/12	43	111	154
2012/13	46	147	193

This data also identifies that the highest rates of hospital admission for self-harm are amongst 15-24 year olds.

Young people aged 10 to 24 years resident in York who were admitted to hospital as a result of self-harm

	Age group (years)				Total
Financial year	10-14	15-17	18-20	21-24	10-24
2007/08	18	42	66	42	168
2008/09	17	40	55	78	190
2009/10	13	50	74	56	193
2010/11	13	28	57	52	150
2011/12	18	32	51	53	154
2012/13	22	61	63	47	193

Source: Public Health England, Child and Maternal Health Intelligence Network; Hospital Episode Statistics (HES).

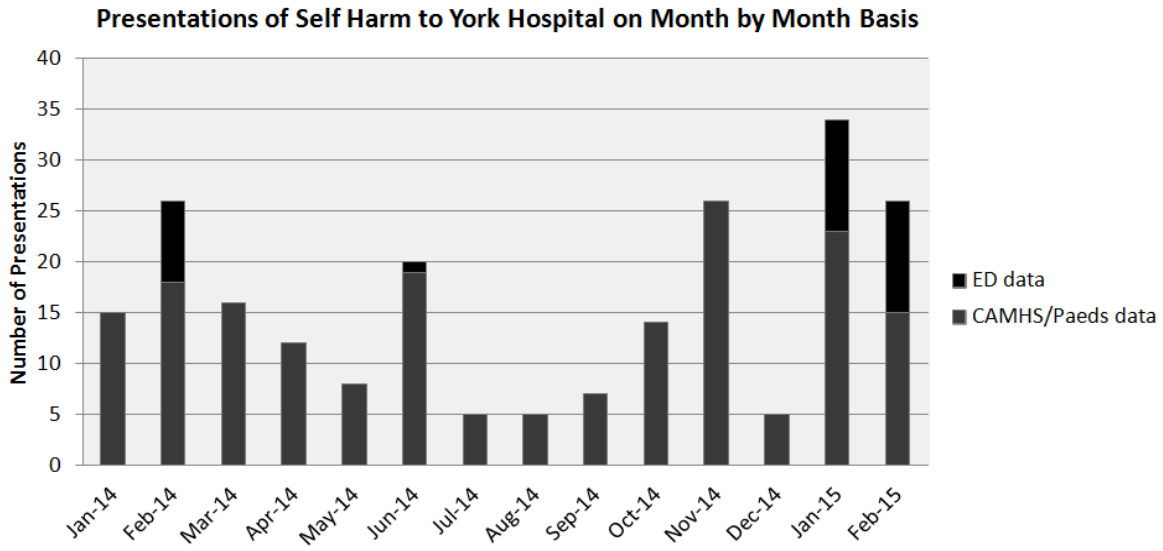
An audit into Child and Adolescent Mental Health Service (CAMHS) completed by Dr. Govenden and Dr. Sykes is summarised below.

Activity data was collected from hospital records of admission to the children's ward and CAMHS documentation of referrals received. Emergency department attendances for all conditions were reviewed for

certain key months between January 2014 and February 2015 for all children aged 10-18 years.

This reported that between January 2014 and February 2015 there were 214 presentations to York Hospital Emergency Department (ED) by 119 children and young people with self-harm and/or suicidal thoughts. Of these children, City of York residents accounted for 91 of 119 children (76%) and 167 (78%) attendances.

The graph below shows the number of children and young people presenting with self-harm. For February 2014, January 2015 and February 2015 data was checked against ED records and additional presentations were found. Shown is the combined total for all records.



The graph shows seasonal variation in presentations with self-harm. There is a rise during the exam period (June) but otherwise the summer months have fewer presentations. In the second half of the study period (July 2014-February 2015) there are more presentations, 117 in total, compared to the first half which saw 102 total presentations.

Key findings were as follows:

- 24 boys (20%) account for 47 (22%) attendances, 95 girls (80%) account for 167 (78%) attendances.
- Young people aged 16 and 17 years accounted for 50% of the total attendances, the youngest child seen was 9 years, the oldest was 18 years.

- Approximately 8% of children in this group are looked after, compared to a city rate of 245 per 10,000 population (2.5%), making them significantly over represented in this group.
- 89% of children seen had a documented risk assessment carried out by medical staff in ED, CAMHS or paediatrics.
- Of 214 presentations: 153 (71%) were admitted; 24 (11%) were discussed with CAMHS and discharged, 4 (2%) self discharged; 25 (12%) were seen and discharged with no risk assessment documented; 8 (4%) had other outcomes.
- 137 (64%) presentations involved overdose of medication or other harmful substances. Of these, 94 included paracetamol. 43 (20%) attendances were due to self injurious behaviour, including one young man found unconscious after an attempted hanging. 34 (16%) presentations were due to increasing thoughts of suicide, self-harm or feeling unsafe.
- Most children stated they felt very low in mood and where a particular trigger was documented, the majority of children and young people cited family issues and arguments as the reason for their self-harm. Issues with relationships, school or work stress, bullying, police visits or court cases and being the victim of sexual assault were also given as reasons for self-harm.
- Many of the children and young people seen in this audit presented only once to ED but a key minority presented over 3 times during the study period.

There were a number of limitations in gathering accurate data for this audit. Only presentations where there was documentation of self-harm intent or suicidal thoughts were included in the audit. Cases of indirect self-harm such as presenting with anxiety, intoxication from alcohol or other substances, or from punching a wall, whilst identified, were not included in the audit. This would indicate that if the criteria for identifying self-harm were broadened, that it would be likely that more children would be identified. The audit only looked at attendances of children and young people under 18.

The audit reported that the majority of the children and young people presenting with self-harming injuries were appropriately assessed and

referred for treatment. During the period of this audit, CAMHS carried out at 147 assessments on children and young people admitted to the paediatric ward. Comparison is made between this figure and data from the City of York Children's and Young People's mental health strategy 2013-2016 document which states that in 2011-2012 '80 young people were seen in hospital by the CAMHS duty team following an overdose or other serious form of deliberate self harm.'

From the data gathered it is clear that there are high levels of children and young people who self-harm in York. A disproportionate number of these children and young people are looked after and the majority of those seen in hospital cite difficult family relationships as the trigger for their self-harm. It is not surprising that those children and young people who lack robust emotional support appear to be at greater risk of harming themselves. Any actions that can be taken to strengthen vulnerable families and that foster emotional resilience in young people are likely to be of great benefit to the mental health of our community.

The audit identifies a range of suggested actions:

- Clear referral pathways: ED has already implemented a new referral pathway for children presenting with self-harm and they are transferred to paediatrics directly for further assessment.
- Consultant review after multiple presentations: CAMHS may consider that a person presenting for the 3rd time within a given period may need more senior review and possibly be considered for admission.
- Clearer coding: ED is currently planning to update their coding system to try to better capture the number of presentations to the department.
- Crisis team in ED: with additional staff training, the ED-based crisis team may be able to directly assess and manage 16 and 17 year olds presenting with self-harm which could potentially lead to more satisfactory outcomes for those young people and reduce the number of inpatient stays.

- Training: ensure all ED and paediatric staff are adequately trained in conducting risk assessments of children and young people.

It would be useful to replicate this audit assessment within the adult (18+) population to understand how well people in high risk groups for self-harming behaviour based on age e.g. 18-25 year olds and those in high risk groups of immediate risk of suicide e.g. over 65 year olds are being assessed for mental health support needs following identification of self-harm.

An Emergency Department Liaison Service is a year-long joint pilot scheme operating in York which was established in October 2014 in response to difficulties managing presentations involving mental ill-health in the ED, dissatisfaction with the service provided to York Hospital by local mental health services, and an overall national drive to improve the service provided for patients with complex physical and mental health needs.

Since January 2015, the team has provided on demand psychosocial assessments for anyone over 16 years of age, presenting to the ED department at York District Hospital 24 hours a day 7 days a week, with an expected response time of less than 3 hours becoming a 2 hour response time from April 2015.

The aims of this service are to reduce breaches, reduce inappropriate admissions, reduce repeat attendance, and facilitate early identification of mental health issues and appropriate signposting and onward referral to secondary mental health service, voluntary services or primary care.
Another function is providing supervision, education and support for the ED staff. The overall goal is to improve the service provided and experience of patients and carers attending the ED, improve collaborative working and links with ambulatory care pathways in ED, with primary care and community mental health services.

This service is limited to the ED so any patients moved on to the medical wards, presenting with mental ill-health on e.g. maternity wards or surgical wards, or presenting with labour and time intensive complex

physical and mental health needs are seen under existing arrangements on an ad hoc basis by the on call psychiatry staff.

A future aim of this provision following the pilot might be to extend the Liaison service in order to support all of York Hospital, working collaboratively with existing services such as psychology, the old age psychiatry team ('MHALT'), the substance misuse liaison team, and developing links between services such as maternity and the proposed perinatal psychiatry service. This would allow expert liaison psychiatry input to improve the psychological care of patients in York District Hospital, promote positive mental health, reduce stigma and ensure parity of esteem between mental and physical health and wellbeing needs.

Due to a recent transfer in service provider of this pilot programme access to activity data is not available for use in this report. This was further complicated by the CQC closure of parts of Bootham Park hospital where this service and its staff are based.

Gaps in data

There is a lack in data around how self-harming behaviour that does not result in presentation to emergency department services or results in a hospital admission is recorded.

A range of services were asked to contribute to the local intelligence about self-harm.

Whilst good practice was described across a number of services in a number of ways that ensured risks for an individual were being identified, it became apparent that self-harm is often not something that is quantified within services.

LOCAL SERVICES

GP Surgeries

GP practices across NHS Vale of York Clinical Commissioning Group were asked to contribute to this report about the scope of self-harm that is identified by GP's. Only one response was received which highlighted some concerns about:

- a lack of consistency in how self-harm is recorded on GP systems
- a lack of confidence in being able to identify those at risk of self-harm
- a lack of effective referral options where self-harm is identified
- a lack of information and support resources available
- attempts to use internet resources but there not being a clearly identified resource

Practices were asked to respond to a brief questionnaire and to supply any other additional information that would contribute to increasing local understanding about self-harming behaviour and its prevalence in the local area. Given the lack of responses to this request, it is difficult to know whether the views highlighted above are shared across all GP's in the clinical commissioning group.

Counselling Services

A number of services offering counselling support were approached to comment on how prevalent self-harm is within the local area. Many of the responses identified a lack of clearly available data around how many people accessing support services were doing so where self-harm was known to be an issue. That is not to say that services didn't feel able to identify self-harm through their assessment processes or through

the development of the therapeutic relationship which allowed the person being counselled to feel comfortable enough to tell their counsellor about their self-harming behaviour.

York St. Johns University Wellbeing Service responded to identify that from August 2015, quantitative information about students who report self-harming behaviour or / and suicidal ideation within their existing risk assessment processes will be recorded to give an overview of the service as a whole in relation to numbers of students presenting with self-harming behaviour. Currently, there are no figures available at a service level; however, risk assessments are routinely carried out with students at appointments using a CORE-34 tool which allows self-harm to be identified and to track changes in this and other risk factors.

The York St. Johns service supported over 700 students in the academic year 2014-15 and estimate that at least half will have presented with some form of self-harming behaviour. The most common self-harming behaviours supported were students who are cutting (usually arms/thighs/stomachs), overdosing (but not with the intent to end their life), head-banging, burning and engaging in damaging eating habits (starving, binging, purging).

The service reported that generally speaking students will either overtly want to discuss/show what they have done, or conversely they will be very reluctant to talk about or acknowledge their self-harm.

The range of support offered in relation to self-harm if students wish to reduce their risk and try to more safely manage their self harm a more detailed risk assessment and safety plan is completed with the student. The service may also do some work with them on how they can make the help-seeking process more accessible for them. For example, this might involve completion of a leaflet which communicates to healthcare professionals what injury they have sustained and how (we use the Indigo project template). This work is done by either our Mental Health Advisors or Counsellors.

The service operates a daily (Mon-Fri) drop-in service which allows staff to routinely assess risk in a prompt manner and take appropriate action.

We also respond to concerns from peers, family, academic staff and any other source who has a significant concern about a student's self-harm. The level of response to these concerns will vary depending on the information provided and any additional knowledge about the student.

The service manager wished to stress that, from her experience in this field, she believes this area to be significantly under-reported, especially in medical statistics, as the majority of people who are self-harming rarely seek support, and very few would actually seek medical intervention.

Castlegate provided a range of information about their counselling services and were also able to identify how many people accessing counselling support reported self-harming. During 2014-2015, 219 people were seen for counselling with an additional 94 expressing an interest in accessing counselling but not accessing it.

Of the 219 clients seen, 77 were people who were self-harming or had self-harmed. Of these, 27 were male and 50 female. 32 were aged 16 – 19 years old and 45 were aged 20 years old or over.

In addition to information about self-harming behaviour, information about suicidal thinking is recorded. Of the 219 clients seen, 87 reported suicidal thinking, 33 of these were male and 54 female. 33 were aged 16 – 19 years old and 54 were aged 20 years old or over.

Of the 219 clients seen, 26 reported having made a suicide attempt, 10 of these were male and 16 female. 9 were aged 16 – 19 years old and 17 were aged 20 years old or over.

Emergency Services

Yorkshire Ambulance Service (YAS) operate the non-emergency medical helpline number – 111 and have provided data about the calls received from people registered to any NHS Vale of York Clinical Commissioning Group GP practice between April 2014 – March 2015 where wound care / self-harm was the reason for calling.

There are some limitations with this data where some of the categories recorded may indicate wound care that is not directly a result of intentional self-harm.

During this period, there were 5,091 calls that were related to wound care or self-harm queries.

Calls to 111 non-emergency helpline in relation to wound care/self-harm

Age band	Apr -14	May-14	Jun -14	Jul -14	Aug -14	Sep -14	Oct -14	Nov -14	Dec -14	Jan -15	Feb -15	Mar-15	Grand Total
under18	153	152	158	150	122	156	159	159	122	138	126	158	1,753
18-64	160	166	156	149	159	151	185	210	202	233	179	226	2,176
over64	74	93	101	79	73	80	99	107	125	124	100	107	1,162
Grand Total	**387**	**411**	**415**	**378**	**354**	**387**	**443**	**476**	**449**	**495**	**405**	**491**	**5,091**

Source: Yorkshire Ambulance Service

Calls made to the emergency 999 number are not specifically coded as self-harm related so it is not possible to extract robust and reliable information about the number of calls to the emergency 999 number about self-harm related incidents. However, there are 7 codes that could be related to self-harm which would account for just under 3,000 out of over 15,000 calls from people registered to NHS Vale of York Clinical Commissioning Group practices.

The most likely codes to indicate self-harm are the ‘overdose/ingestion/poisoning’ and ‘psychiatric/suicide attempt’ codes.

Calls to emergency 999 number which may relate to self-harm

Row Labels	Under 18	18-64	over 64	NULL	Grand Total
Breathing Problems	73	310	447	19	849
Burns/Explosion	10	7	3	10	30

Haemorrhage/Lacerations	23	123	178	11	335
Overdose/Ingestion/Poisoning	51	228	16	24	319
Psychiatric/Suicide Attempt	31	247	15	27	320
Traumatic Injuries, Specific	68	200	67	20	355
Unconscious/Passing Out	44	356	268	41	709
Total (possible self-harm as above)	**300**	**1,471**	**994**	**152**	**2,917**
Grand Total (all reason 999 calls)	**1,139**	**5,796**	**7,085**	**1,631**	**15,651**

Source: Yorkshire Ambulance Service

North Yorkshire Police record known risk factors for the people they interact with. Between 1st April 2012 – 31st March 2015, 335 flags were recorded on the police database to identify self-harm as a known risk factor among children aged under 18.

There are limitations with this data because it is not clear how current and accurate this risk factor data is for all of these individuals and the only time a risk factor is recorded if this is made known to the police officer or PCSO. Risk factors around self-harm are only identified for the people that come into contact with North Yorkshire Police so do not represent a comprehensive prevalence rate across the entire population.

Of the 335 risk factors identified, this represented 251 individuals, 32 of whom were children in the care system. 147 of the risk flags were for males which represented 115 male individuals. 188 risk flags were for females which represented 136 female individuals.

Telephone Support Services

York Nightline is a student listening support service open from 8pm until 8am every night of the University of York term.

The service and organisation is 100% confidential. Nightline does not keep any records of individual callers, they don't ask anyone's name, and everything shared remains completely confidential.

Nightline was not asked to supply any information towards this piece of work because of their principles:

- Confidential: All calls to Nightline are confidential: we won't divulge anything in your call to anyone outside the service.
- Anonymous: We won't make any attempt to find out who you are – we won't even ask your name. Nightline volunteers are anonymous themselves. The reason that Nightline volunteers remain anonymous is to make clear that they only represent Nightline while on duty and that when not on duty they are just another student. The only exceptions to this rule are our Public Faces. However, they no longer do nights or take calls.
- Non-Judgmental: We have no political, religious, ethnic, cultural, political or moral bias. We accept and respect the views of any caller, and we won't criticise or judge you for anything you've done.
- Non-Directive: We won't try to steer you towards any particular course of action, or try to get you to think about your situation in any particular way.
- Non-Assumptive: We don't make assumptions about our callers; we let our callers explain their situation in their own words and in their own time.

Nightline can be contacted on **01904 323735** every night of term from 8pm - 8am or by dialling 3735 from any campus phone.

The Nightline website provides a range of information about self-harm and links to support for people who self-harm which can be accessed at: http://www.yorknightline.org.uk/new-page-66/

Samaritans are a national charity providing listening support to anyone about whatever is troubling them; you don't need to be suicidal to call. Similar to Nightline, because of their organisational principles of complete anonymity and confidentiality to whatever the caller says, Samaritans were not approached to contribute to this piece of work with any information or data. York Samaritans can be contacted on **01904 655 888** (local call charges apply) or free on **116 123** (this number is free to call). Their website is: http://www.samaritans.org/branches/york-samaritans

Schools

A local pilot programme to place qualified mental health support workers in local schools begun in November 2015. It is too early in this pilot approach to provide any information from this scheme for the purpose of this report. However, it is expected that this programme will bring a number of benefits to the mental wellbeing of local students by providing a visible point of contact for pupils who may be experiencing distress. By making access to support more accessible and safe for students whilst reducing the stigma associated with mental health problems, it is expected that there will be a range of positive outcomes for the schools and the pupils who attend them.

Personal Social Health Education programmes run in every school. No detailed information is given in this report about what elements of these lessons are provided within local schools that may help pupils to build resilience, raise awareness about self-harm risk factors, or to provide information to pupils on how to find alternate methods of coping, or to seek help in relation to mental health or self-harm specific issues.

Exams are identified as particular stress points for young people and local student support services report spikes in need for support and increases in self-harming behaviour at exam times.

Voluntary Sector

A range of support services for people experiencing mental ill health or distress are provided across the local authority and clinical commissioning group area, however, no specific information about the extent of self-harm that these services support has been identified. The type of support offered includes support groups for people, information, advocacy, counselling and training for people to build resilience and skills such as Mindfulness.

ANNEX 2

RESPONDING TO SELF HARM

Safeguarding

The City of York Safeguarding Children Board Threshold Guidance identifies self-harming behaviour among young people as requiring a level 3 statutory response across all age groups of children up to 18 years of age.

Universal	Level 2 emerging	Level 2 escalating	Level 3
Emotional Health	Good state of emotional health. Good emotional development and responses. Appropriate expression/ recognition of emotions. Appropriate facial expression.	Infrequent, inconsistent emotional problems/responses E.g. expression, recognition, facial expression. Vulnerable to emotional problems e.g. following divorce, separation or bereavement, relationship / friendship breakdown. Unduly anxious, angry, defiant or withdrawn.	Frequent significant emotional problems/responses e.g. expression, recognition, facial expression e.g. arising from divorce, separation, step parenting, bereavement, relationship/friendship breakdown. Emotional health/appearance deteriorating/problems emerging e.g. conduct disorder, Attention Deficit Hyperactivity Disorder, anxiety, eating disorders.

Where self-harming is identified, a level 3 response requires a Child in Need (S17) assessment and intervention. During 2014 – 2015, there were a total of 691 of these assessments completed and self-harm was

identified as the reason in 1.4% of these. For the year date since 1st April 2015, the assessments where self-harm featured equates to 4% of the 363 completed to date (as at 27th November, 2015).

Perceptions around self-harm

In 2006, The Mental Health Foundation published a report into self-harm called 'Truth Hurts' in which they identified how the young people they spoke with to help prepare the report identified negative experiences of asking for help which often made things worse for them. Many were met with ridicule or hostility from the professionals that they turned to.

For the purpose of this report, three people from the local area who have self-harmed were interviewed about their experiences of self-harming, seeking help and recovery in this area. These three people's experiences differed because of their personal circumstances, the routes they explored to get help, the support they received and their recovery proves. All talked directly about experiences of support in York and all had sought and received help and were now in a position where they reported no longer self-harming. However, all identified similar issues of not feeling able to easily ask for help; not knowing who or where to go to for help; of feeling dismissed when talking about their self-harm as identified in the 'Truth Hurts' report.

Other feedback of their local experiences included:

- A lack of awareness amongst health professionals about self-harm. This ranged from:
    - staff using self-reported harming behaviour as a means to assess the stability of depression.
    - being told that the self-harming would never stop
    - never feeling able to go to A&E because of the lack of empathy and compassion experienced
    - never being given any advice about other ways of coping or about harm minimisation or wound care

- feeling that the support offered took too long to be given, particularly if experiencing a crisis;
- that there was a distinct lack of advice given about other ways of coping;
- a lack of harm reduction advice given and an expectation from staff in services supporting these people that they should stop their self-harming behaviour. Examples of situations were given where self-harming behaviour was not tolerated by ward staff in hospitals with a result being to discharge a person who had self-harmed whilst on the ward. Other examples were given where teaching staff were asking to see pupil's arms to make sure that they were not cutting themselves which had the effect of pupils choosing other sites on their bodies to cut and then not wanting to talk to anyone about their self-harming behaviour;
- that ongoing support is crucial to help maintain recovery from self-harming behaviour. This could include having access to a mental health support line to turn to. For one of the people, this resource had been invaluable but was being withdrawn as a resource.
- all had tried accessing support groups, either in person or on-line but predominantly on-line and these were reported to be good supportive groups. However, the risk associated with on-line groups was raised as a concern because some sites can be harmful and it is essential to find a well moderated site that was run with the interests of the safety of the people using it in mind.

A report written by NHS Health Scotland in 2014 also identified a need to improve the experience of care for people who have self-harmed. The experiential evidence provided above and the fact that the issue of improving patient experience around self-harm is still being identified as a need, suggests that people who self-harm are still having negative experiences of seeking help. Whilst this is still the case, it is likely that the numbers of people feeling able to ask for help in connection to their self-harming behaviour will remain low.

NICE CG16 and CG133 (2004; 2011) guidance identifies a number of areas requiring implementation in the care of someone who has self-harmed which includes a focus on developing a supportive relationship

with the person; completing a comprehensive assessment of need and risk; developing a care plan; sharing information with the person's GP and offering an appropriate level of ongoing support which accounts for other mental health support needs and personal circumstances.

The Royal College of Psychiatrists (2010, 2014) recommends that a public health approach towards self-harm should include elements of staff training across a range of sectors; the provision of information and advice; and should identify responses to growing concerns about the internet, social media and social isolation.

Evidence for Interventions

A 2010 evidence review (Wood, S. et al, 2010) report which reviewed a range of interventions effective in preventing, supporting and reducing self-harm and suicide suggests that the following interventions might have some benefits if applied locally:

Developing awareness and skills: School-based education programmes can improve knowledge, attitudes and help-seeking behaviours. Programmes that develop coping skills can improve attitudes towards suicide and reduce suicidal ideation. They have shown promise in reducing both completed and attempted suicides.

Increasing identification and referral: Although findings have been inconsistent, training for health care professionals to improve awareness of suicide has had positive short term effects on suicides and suicide attempts. Training for gatekeepers (other professionals in contact with at-risk groups) can reduce suicide and increase use of mental health services when used as part of wider multi-component interventions.

Supporting and treating those at risk: Help lines can have small effects on levels of suicide when included in services at suicide prevention centres (that also provide outreach and awareness campaigns). There is some evidence that psychotherapy can reduce suicidal ideation, suicide attempts, and repetition of suicidal/self harm behaviour. Among people attempting suicide, professional contact a year after discharge from hospital can reduce the number of reattempts.

Among some high-risk groups (e.g. those with mood disorders), drug treatments can prevent suicide attempts.

Community interventions: At hotspot areas, the use of safety fencing or signposting to support services can reduce suicides. Multicomponent community interventions that combine a variety of initiatives (e.g. education, training for professionals and support) can also reduce rates of suicide.

Societal measures: Restriction of access to lethal means can be effective in reducing suicide rates. Although evidence is limited, the introduction of media guidelines on suicide reporting has been associated with positive changes in reporting as well as decreases in annual suicide levels.

NHS Health Scotland (2014) identifies a range of measures that are recommended to include in local service provision arrangements:

Focus	Actions and interventions
Society	Social protection
	Restricting availability and access to lethal means
	Reducing affordability of alcohol
	Improved media reporting
	Public education campaigns
	National suicide prevention programmes
Community	Building community resilience and connectedness
Individuals	Gatekeeper training
	Screening
	Primary care interventions
	Assistance to family/friends of high-risk individuals
	Postvention
Specific populations	School-based suicide prevention programmes
	Prison-based prevention programmes
	Drug misuse programmes

Source: NHS Health Scotland

Social media is a resource that has potential for benefits and harms to those who use it in relation to self-harm. There is concern over the influence of social media but limited systematic evidence, despite stories

of individuals who have been bullied or encouraged to self-harm. This has to be balanced against the support that vulnerable people may find through social networks. A recent systematic review of the research literature has confirmed that young people who self-harm or are suicidal often make use of the internet. It is most commonly used for constructive reasons such as seeking support and coping strategies, but may exert a negative influence, normalising self-harm and potentially discouraging disclosure or professional help-seeking (Department of Health, 2015).

Locally defined approach

Developing a co-ordinated approach across services which supports increased understanding of the needs of our local population around self-harm, the prevalence of it and an ability to be better able to respond to at risk groups; training and development to more effectively identify and support people who do self-harm along with improved data collection; a defined approach which allows support and services to be developed in line with best practice guidance such as NICE CG16 and CG133 self-harm guidance for short and long term management and prevention of self-harm.

Developing a co-ordinated approach between local suicide prevention plans and self-harm would acknowledge the interconnectedness of these two issues.

Developing a locally relevant training, information and advice offer around self-harm would support recommended approaches to improve the patient journey for someone who self-harms, to be able to offer support based on best practice and to create accessible and high quality resources for a range of people.

Developing local pathways into support services for someone who self-harms would help to more clearly identify how people could access support and to make the offer of support much more visible.

Exploring how technology and resources like social media can be better utilised to allow people who self-harm to be able to support themselves in a safe way and to access information and advice.

To consider how family and friends can be supported where self-harming behaviour is occurring in someone they care about.

The North Yorkshire Police / York University Mental Health Research Project has an objective to produce some locally relevant research into self-harm.

There is a clear need to improve the experience of care for those who have self-harmed.

Self-harm is a complex mix of risk and protective factors which vary across the course of a person's life. It is likely that a range of preventative actions and interventions will be needed.

Consideration could be given to local evaluation of interventions so that clear outcomes can be measured which will contribute to our understanding of what works.

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ANNEX 3

Protecting children in the City of York

Self-harm and suicidal behaviour

Working with children and young people in York

October 2017

CITY OF YORK COUNCIL

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Produced by York's Strategic Partnership, Emotional & Mental Health (Children & Young People)

Contents

"When I self-harm it is me telling the outside world what I feel inside, which I can't express in words. Often it is an alternative to me attempting to kill myself, and all that I really want is someone to hug me and let me talk to them."

"The most important thing is not to tell people to stop, but to listen to them, find out what they need to stop and help them find ways of achieving that."

"My doctor looked at me differently once I told her why I was there. It was as if I were being annoying and wasting her time."

Quotations from Mental Health Foundation, 2010

Introduction

Dear Colleague,

On behalf of the Strategic Partnership, Emotional & Mental Health (Children & Young People), I am pleased to share this self-harm and suicidal behaviour information booklet with you.

This useful resource offers guidance for staff working with children and young people under the age of 18 (under 25 for those with disabilities or for care leavers) in York who self-harm or feel suicidal. It is not intended for colleagues who work within the mental health sector; instead it is targeted at people who work with children/young people in a wide range of universal settings such as schools and youth or community groups. Everyone can play a part in helping children and young people who may be at risk.

The booklet sets out some key principles and ways of working but does not prescribe how to act in individual situations.

The information included in this resource is not intended to override individual organisational or professional guidelines where they already exist. It can however be used as a prompt for discussions about organisational approaches to working with self-harm and suicidal intent, or to highlight training needs.

The Strategic Partnership, Emotional & Mental Health (Children & Young People) would like to thank colleagues in Leeds for their work in developing much of the material included in this booklet.

I hope you find this information helpful.

Eoin Rush
Chair, Strategic Partnership, Emotional & Mental Health (Children & Young People)

Self-harm/self-injury/self-poisoning

Injuries that have been caused on purpose are considered to be acts of self-harm, and research suggests that, in the UK, 1 in 15 young people has self-harmed[1]. The terms 'self-harm', 'self-injury' and 'self-poisoning' describe a wide range of physical behaviours including:

- cutting, often to the arms using razor blades, broken glass or knives
- scratching, scraping or picking skin
- burning, sometimes with cigarettes or scalding
- scouring or scrubbing the body excessively
- inserting or swallowing inedible objects or hazardous materials or substances
- banging/hitting/punching/bruising the head or other parts of the body
- pulling out hair or eyelashes
- inhaling or sniffing harmful substance/aerosols
- taking an overdose of tablets (whether these are prescribed or not)
- alcohol, drug and substance misuse
- eating disorders.

Self-harm often happens during times of anger, distress, fear, worry, depression or low self-esteem.

Some young people self-harm to cope with, or find relief from, difficult and distressing feelings, an overwhelming situation or an emotional state, or as a form of self-punishment. Self-harm in young people often co-exists with other difficulties such as substance misuse, poor school attendance, low academic achievement, bullying, domestic violence, victimisation and child sexual and physical abuse.

Many young people do not see abusing drugs and alcohol, having an eating disorder, taking risks or putting themselves in a risky situation as self-harm. Whilst it is important for professionals to recognise these behaviours as self-harm, they are not always a sign of difficult and distressing feelings.

Self-harm in its broadest sense incorporates eating disorders as a form of self-harm to a child or young person's health and body. But there are also links between self-harm and different types of eating disorder.

[1] Mental Health Foundation (2006). *Truth hurts: report of the National Inquiry into self-harm among young people*. London: Mental Health Foundation.

The prevalence of self-harming in young people with eating disorders is thought to be about 25%, particularly in young people who engage in the binge-purge cycle of bulimia. For many, self-harm and an eating disorder can co-exist but for others the self-harming behaviour may be to replace an eating disorder or vice versa. (www.selfharm.co.uk/get/facts/self-harm-and-eating-disorders)

Self-harm is not always about ending life, however sometimes young people say they feel unsure whether they want to die or not. Some young people do have suicidal thoughts and feelings and sometimes they harm themselves in ways that are very dangerous.

Isolated young people with little or no support systems in place are particularly vulnerable and a cause for concern. These include young people who are homeless, not in education, employment or training, or those who have little or no support in their family due to parental mental or physical illness, parental substance misuse or family relationship breakdown.

Self-harm may be an attempt to communicate with or secure help from others but, in the vast majority of cases, self-harm remains a secretive behaviour that can go on for a long time without being discovered. The behaviours can be very addictive.

Who is most vulnerable?

One in ten children and young people have a diagnosable mental health need (No Health without Mental Health 2011). Children and young people experiencing the following additional needs or difficulties are particularly vulnerable:

- high anxiety
- Autism
- known to abscond from school
- runaways
- children in care or custody
- deaf children.

Triggers

A number of factors may trigger the self-harm incident, including:

- family relationship difficulties (the most common trigger)
- difficulties with peer relationships e.g. break-up of relationship (the most common trigger for older adolescents)
- bullying
- significant trauma e.g. bereavement, abuse

- self-harm behaviour in other young people (contagion effect)
- self-harm portrayed or reported in the media
- difficult times of the year e.g. anniversaries
- trouble in school or with police
- feeling under pressure from families, school or peers to conform or achieve
- exam pressure – either through feelings of lack of ability or preparation, or feelings associated with 'perfectionism'
- times of change, e.g. parental separation/divorce
- feeling out of control.

Warning signs that a child may be self-harming

The following behaviours may suggest that a child is self-harming:

- changes in eating/sleeping habits (e.g. child may appear overly tired if not sleeping well)
- increased isolation from friends or family, becoming socially withdrawn
- changes in activity and mood e.g. more aggressive or introverted than usual
- lowering of academic achievement
- talking or joking about self-harm or suicide
- risk-taking behaviour (substance misuse, unprotected sex)
- expressing feelings of failure, uselessness or loss of hope
- changes in clothing e.g. loss of pride in appearance and being reluctant to roll sleeves up in front of other people or wearing long sleeves even in very hot weather
- increased levels of aggression or bullying
- obvious cuts, scratches or burns which do not look accidental in nature
- frequent alleged accidents which cause physical injury
- regularly bandaged limbs
- reluctance to take part in physical activity which requires a change of clothing
- refusal to take off their jumper or constantly pulling their jumper down over their wrists and hands
- giving away possessions.

Risk factors

Individual factors:

- depression/anxiety/mental health issues
- poor communication skills
- low self-esteem, not feeling very good or confident about themselves
- poor problem-solving skills
- hopelessness
- impulsivity
- drug or alcohol abuse
- sexual identity
- feeling under a lot of pressure at school or at home
- failing (or thinking you are going to fail) exams
- feeling isolated or lonely
- loss, separation and bereavement
- being hurt by others: physically, sexually or emotionally.

Family factors:

- unreasonable expectations
- issues within the family home
- neglect or physical, sexual or emotional abuse
- lack of support at home
- poor parental relationships and arguments
- depression, self-harm or suicide in the family
- loss, separation and bereavement
- domestic violence
- drug/alcohol misuse.

Social factors:

- difficulty in making relationships/ loneliness
- break-up of a relationship
- being bullied or rejected by peers
- arguments with family and friends.

Why does self-harm continue?

Once self-harm (particularly cutting) is established, it may be difficult to stop as it becomes a way of coping. Self-harm can have a number of functions for the child or young person, including:

- reduction in tension (safety valve)
- distraction from problems
- a form of escape
- outlet for anger and rage
- opportunity to feel
- way of punishing self or others
- way of taking control
- care-eliciting behaviour
- a means of establishing an identity with a peer group

- non-verbal communication (e.g. regarding an abusive situation)
- suicidal act
- communication with others that something bad is happening.

When a child or young person inflicts pain upon himself or herself, the body responds by producing endorphins, a natural pain reliever that gives temporary relief or a feeling of peace. The addictive nature of this feeling can make self-harm difficult to stop. Young people who self-harm still feel pain, but some young people say the physical pain is easier to stand than the emotional/mental pain that led to the self-harm initially.

Some young people self-harm not only as a coping mechanism but in order to prevent suicidal thoughts. Paradoxically, self-harm can be a coping mechanism in order to preserve life.

Self-harm may be ongoing and well-managed by the child or young person. One example of this is superficial cutting. This may not require an immediate response but it is still probably a sign of emotional distress and the child or young person still needs support. As a member of staff you may wish to get advice and support to help you work with the child or young person to access services.

Contagion, multiple or copycat behaviours

When a child or young person is self-harming it is important to be vigilant in case close contacts of this individual are also self-harming. Occasionally schools or residential settings may discover that a number of young people in the same peer group are harming themselves.

Self-harm can become an acceptable way of dealing with stress within a peer group and may increase peer identity. Each individual may have different reasons for self-harming and should be given the opportunity for one to one support; however, it may also be helpful to discuss the matter openly with the group of pupils involved. In general it is not advisable to offer regular group support for pupils who self-harm. Where there appears to be linked behaviour or a local pattern emerging, a multi-agency strategy meeting should be convened.

It is important to encourage young people to let a professional know if one of their group is in trouble, upset or showing signs of self-harming. Friends can worry about betraying confidences

so they need to know that self-harm can be very dangerous and that by seeking help and advice for a friend they are taking responsible action and being a good friend. They should also be aware that their friend will be treated in a caring and supportive manner.

Suicide

Young people who self-harm are known to be in a high risk group for future suicide, however suicidal feelings are likely to originate from underlying social, emotional and mental health needs rather than the self-harm itself. In some cases death occurs as a result of self-harm but this is usually accidental and not the intention.

Suicide is still a rare event in young people. Attempted suicides are uncommon in childhood and early adolescence, but increase markedly in the late teens and continue to rise until the early 20s. Nevertheless all people working with children and young people must be aware of the potential for someone to take their own life and must work together to ensure that no child or young person feels suicide is their only option.

Warning signs that a child may be at risk of suicide

If you feel that a child or young person is at risk of suicide then it is necessary to understand the seriousness and immediacy of the risk. Depression, hopelessness and continuing suicidal thoughts are known to be associated with risk. If the child or young person talks about killing themselves always take this seriously as many young people who do take their own life have previously told a professional about their intention.

The following warning signs may suggest that the risk of suicide is high:

- current self-harm, especially if it poses a risk to the child or young person's health and wellbeing
- talking about or showing particular interest in the subjects of suicide or death, or expressing a connection with or understanding of those who have recently or previously taken their own life
- making comments to suggest ambivalence about the future or that things do not matter because all their problems will be resolved
- thoughts of suicide are frequent and not easily dismissed

- formulating a specific plan to take their own life
- access to the means to take their own life (for example, stock-piling tablets)
- significant drug or alcohol abuse
- perceiving situations to be causing unbearable pain or distress
- previous, especially recent, suicide attempt(s)
- evidence of current or recent mental illness
- limited protective factors that may prevent them from attempting suicide or harming themselves, for example, socially isolated or poor relationships with parents/carers
- lack of support mechanisms when distressed.

What to do if a child or young person confides in you

Responsibility to assess risk

As a professional you are seen as a safe person to talk to. If a child or young person tells you that they have considered, or are considering, self-harm or suicide you may be the first person to whom they have confided. Young people have reported that when they speak to a professional for the first time they want to be treated with care and respect. However, sometimes the response can actually make their situation worse if, for example, they are told to simply stop self-harming or if suicidal thoughts are dismissed as attention seeking. You should:

- listen and explain the limits to confidentiality
- reassure the child or young person it is okay to talk about it
- reassure them that you understand that the self-harm is helping them to cope at the moment and that you want to help
- stay calm and do not judge the child or young person for their actions.

All workers have a responsibility to talk to a child or young person who is experiencing difficulties in order to help them to access the support that they need. You should:

- listen to the child or young person and ask what they would like to happen and what support they would like
- reinforce their efforts to find positive coping strategies

- check what they can do to keep themselves safe
- if possible, clarify who and when someone will speak with them again to help and support them
- provide helpline numbers.

As a professional it is your role to work out the best response for the child or young person, proportionate to the level of self-harm or the issues behind the self-harm. If you are in doubt about what to do next, then seek advice from someone in your organisation, such as a pastoral manager. It is useful if you understand your own relationship to potential risky behaviour and how you deal with daily stress and distress.

This booklet does not contain a formal risk assessment tool as this can lead to a 'tick box' mentality. Instead professionals should use their professional judgement when working with children and young people with complex problems. The following section highlights a series of questions and subsequent actions to consider, dependent on the level of risk that is apparent.

Talking to the child or young person

Unless it is unsafe to do so, talk to the child and their parents. It can be very hard to stay calm and confident if someone discloses that they are self-harming or suicidal, but remember that they see you as someone they can trust and talk to. You do not need to have all the answers, and it is okay to say that you need to go and find out more information. Resist the temptation to tell them not to do it again, or promise you that they will not do it.

You may feel anxious about talking to a child or young person about self-harm and suicide in case you say the wrong thing and make the issue worse. However, it is important to offer reassurance that it is okay to talk about it even if you find it uncomfortable. It is a myth that you may put the idea of suicide into their head. Take concerns seriously and respond in a non-judgemental way.

Do not:

- put off the conversation
- under-estimate the value of your empathy and communication skills

- focus solely on the self-harm issue without considering the underlying emotional distress
- see it as attention seeking or manipulation
- believe that a child or young person who has threatened to harm themselves in the past will not carry it out in the future.

Do:

- see the child or young person, not the issue, this will enable you to talk in a genuine way
- ensure the child or young person knows that disclosing shows courage and is the first step in getting support
- allow the child or young person to take the discussion at their own pace
- ask the child or young person to share what is happening from their perspective
- respond in a non-judgemental way if a child or young person discloses they are self-harming or thinking of suicide
- recognise the value of listening. It can be very tempting to try to problem solve or offer advice. Active listening is likely to be appreciated by the child or young person and can help to build rapport
- do not just focus on the self-harm or suicidal intent, consider the underlying issues
- value your own ability to respond in an appropriate and professional way despite your anxieties
- seek support from other colleagues if you are finding the situation difficult
- be clear about your own organisational policies
- refer on for support or speak to a specialist for advice if you are unsure about the level of risk
- work with other professionals to ensure relevant information is shared when appropriate.

The following list of questions may help you to talk to the child or young person who you suspect is self-harming in order to find out more:

- Would you tell me what has been happening?
- How are you feeling generally at the moment?
- I get the impression that you seem upset/bothered/worried/preoccupied/troubled. What can I do to help?
- I have noticed you have been hurting yourself and I am concerned that you are troubled by something at present. How is this affecting you?

- Do you have any injuries or have you taken anything that needs attention?
- Would you show me any injuries?
- Who else knows about this?
- Would you tell me how you have been harming yourself and whether you have the item with you?
- Have you got what you need to harm yourself?
- Have you thought about when you would do it?
- What self-harming behaviours have you considered carrying out?
- Are you at risk of harm from anyone else?
- Are you using drugs/alcohol?
- What other risk-taking behaviour have you been involved in?
- What have you been doing that helps?
- What are you doing that stops the self-harming behaviour from getting worse?
- What needs to happen for you to feel better?
- What help do you need?
- What support have you already received and what support do you need now?
- I would like to help you and to involve someone who has more experience and training. I would like to ask (insert name of person e.g. counsellor) to see you. Would you agree to this?

The following list of questions may help you to talk to the child or young person who is self-harming and who you suspect is at risk of suicide in order to find out more:

- What has been happening?
- How are you feeling generally at the moment?
- How is this affecting you?
- Have you thought about suicide?
- Have you made plans to take your own life and worked out how you can do it?
- What did you plan to use?
- Have you shared your ideas about taking your life – with whom?
- What have you been doing that helps?
- What needs to happen for you to feel better?
- What help do you need?
- What support have you already accessed and what support do you need now?
- I would like to help you by asking someone with more experience and training to be involved. I would like

to ask (insert name of person e.g. counsellor) to see you. Would you agree to this?

It might be useful to ask the child or young person to think of a time when they felt like self-harming but had not done so. What had they done instead? Try to help the child or young person identify alternative coping mechanisms for themselves. Replacing the self-harm with other safer coping strategies can be a positive and more helpful way of dealing with difficulties. These might include:

- identifying support networks i.e. people in the child or young person's life with whom they can get in touch
- talking to someone who can support them – if they are on their own perhaps they can telephone a friend or family member
- knowing how to access a crisis line or website
- distracting themselves by going out, listening to music, going for a walk/run, undertaking other forms of physical exercise, going to the cinema, reading a book, keeping a diary, looking after an animal, watching TV or by doing anything (harmless) that interests them
- relaxing and focusing their mind on something pleasant – their very own personal comforting place. This could include having a bubble bath, stroking an animal, going to the park or listening to music
- finding another way to express their feelings such as squeezing ice cubes (which can be made with red juice to mimic blood if the sight of blood is important), drawing red lines on their skin, writing a letter expressing their feelings, going into a field and screaming, hitting a pillow or soft object, listening to loud music or undertaking physical exercise.

In the longer term a child or young person may need to develop ways of understanding and dealing with the underlying emotions and beliefs. Regular counselling/therapy may be helpful. Support from family members or carers is likely to be an important part of this. It may also help if the child or young person joins a group activity such as a youth club or a keep fit class that will provide opportunities for them to develop friendships and feel better about themselves. Learning stress management techniques, ways to keep safe and how to relax may also be useful.

Where to get advice

You should seek advice from your line manager or the Child and Adolescent Mental Health Service single point of access as to how to respond and to find out about the services and options available.

The duty worker at the single point of access will:

- provide advice as to whether a referral is appropriate
- speak to the child or young person or their parents within 24 hours of receiving the referral
- undertake a 30 minute telephone assessment for all routine referrals
- provide feedback from the telephone assessment to the child or young person and the referrer within five days
- offer a face to face first appointment within four weeks of the referral, where appropriate.

Tel: 01904 615345 within office hours.

Crisis or urgent need

If you feel a young person is experiencing a mental health or emotional crisis that potentially places themselves or others at risk you can contact the CAMHS Crisis and Home Resolution Team for advice. The team aims to provide a rapid response, prompt advice and assessment and, where appropriate, intensive time-limited interventions for children and young people up to the age of 18, who are experiencing an acute and severe mental health or emotional crisis, which is acutely affecting their functioning. The service aims to work in the least restrictive environment, consistent with the need for their own safety and the safety of others. The service can be provided in a range of settings and offers a genuine alternative to the traditional response of in-patient care or acute hospital admission.

The team operates between the hours of 10am and 10pm and can be contacted on 01904 615348. Should concerns arise outside of these hours, young people may go to the Emergency Department (A&E) for urgent support.

In an emergency

If the situation is an emergency, i.e. if someone has seriously injured themselves or taken an overdose, it is important that they get immediate medical treatment from the Emergency Department (A&E). Call for an ambulance on 999 and ensure parents or carers are involved in this process. If the child or young person has self-poisoned it is

always necessary to seek urgent medical attention from the nearest Emergency Department (A&E) as the nature and quantity of the ingested substances may not be clearly known.

Looking after yourself

Supporting people who self-harm or experience suicidal thoughts is emotionally demanding and requires a high level of communication skill and support. You may experience emotions such as anger, shock, disgust or guilt, so it is important that you have the space and support to reflect on how this impacts on you.

Ongoing support options

Ongoing support systems need to be put in place even if you feel that the child or young person is not currently at risk as this could change at any point. Make sure that you continue to ask them about self-harm and suicidal thoughts.

- Be aware that the individual's reasons for self-harming may be different on each occasion and therefore each episode needs to be treated in its own right
- Discuss concerns with the school nurse, school pastoral lead or school wellbeing worker who may then consult with CAMHS where appropriate
- Some children and young people find it helpful to read leaflets or self-help resources about self-harm, including websites e.g. Young Minds
- Consider completing a Family Early Help Assessment (FEHA).

If you refer on to specialist services for a more in-depth assessment, it is still important that you keep in contact with the child or young person on a regular basis.

Parents/friends - It is important to consider the supportive role that parents or carers can play in keeping a child or young person safe. This may be a supportive relationship but it is important not to assume so. It is good practice to discuss with the child or young person whether they wish to tell a parent or carer about how they are feeling. If the child or young person decides that they do not wish to tell their parent/carer then this must be respected although you should explore the reasons behind this. In cases of an abusive home life it may not be in their best interest to inform parents as it may increase the risk to them. The only time you should break this confidence is if there is a serious risk of harm to the child or young person in not doing so.

Schools - If a child or young person is at school, support for emotional and mental health is provided by teachers, the school nurse, the school wellbeing worker, emotional literacy support assistants and pastoral staff. You should speak to the child or young person's headteacher about accessing this support.

Some educational settings have their own counselling services on site. The Department for Education has published guidance for schools to ensure that services provided are of good quality (DfE Counselling in schools: A Blueprint for the Future) - Departmental advice for school leaders and counsellors (2016).

College/university - If a young person is at college or university, direct them to the support networks and pastoral staff/tutors or counsellors available.

GP - A child or young person's GP can offer advice and confidential support.

Self-help/online counselling - Some children and young people find it helpful to read leaflets or self-help resources, or seek advice online. Please see the list of local and national websites at the end of this booklet.

Safeguarding

This guidance is not intended for use in circumstances where there is an immediate threat to life or risk of significant physical harm. If you have serious and immediate concerns regarding the safety of a child or young person you should contact the emergency services by dialling 999.

Worried about a child – make a referral

You can make a referral to Children's Social Care if you are worried about a child or young person and think they may be a victim of neglect or abuse.

Professionals in all agencies have a responsibility to refer a child to Children's Social Care when it is believed or suspected that a child is at risk of, or has suffered, significant harm and/or:

- is likely to suffer significant harm, and/or
- has developmental and welfare needs which are likely only to be met through provision of family support services (with agreement of the child's parent).

The City of York's referral form is available to download on the Safeguarding Board website: www.saferchildrenyork.org.uk/forms.htm. Completing this standard form will ensure all the necessary, relevant information is provided so that the referral can progress as effectively as possible. If you require advice prior to completing a referral form, please ring the Referral & Assessment Team (Front Door) and speak to the duty social worker.

During office hours:
Referral & Assessment Team
Tel: 01904 551900 or email childrensfrontdoor@york.gov.uk

Out of hours, at weekends and on public holidays:
Emergency Duty Team
Tel: 01609 780780 or email edt@northyorks.gov.uk

Working with children and young people with learning disabilities

Young people with any level of learning difficulty or disability can demonstrate the same type of self-harm behaviours as other young people and should be supported in the same ways, as outlined throughout this booklet. There is a strong link between Autism and mental health difficulties. 70% of children with Autism develop mental health problems, while 16-35% of autistic adults have a co-morbid psychiatric disorder ('Supporting people living with Autism Spectrum Disorder and Mental Health Problems', Mind 2015).

It is important to contact key professionals and parents to find out what the child's learning needs are and how best to communicate with them. If they have Autism or Asperger syndrome or significant learning difficulties, different communication skills will be needed to discuss these issues. It is important to seek advice.

The types of therapeutic interventions that they are offered would need to be adapted to reflect their needs, but the referral routes into specialist services would be via the CAMHS single point of access. Advice can also be sought from their health and disability social worker or their school.

If a child or young person is in need of support from Children's Social Care it would go via the children's front door on 01904 551900. If they are an adult it would be via Customer Advice and Assessment Team on 01904 555111.

Certain young people are at heightened risk of self-injurious behaviours and self-harming, including those with more severe learning disabilities, those with little or no verbal communication, including children with Autism and Asperger syndrome, those with an acquired brain injury, and those with mental health conditions, particularly those with late diagnoses, as well as those with certain rare genetic conditions, and young people with a sensory impairment. Children in these groups who begin to display self-injurious behaviours should be referred to specialist CAMHS as the longer such behaviours occur, the less likely they are to respond to intervention.

Young people with a severe or profound learning disability are less likely to display traditional forms of self-harming behaviour. Their emotional distress is much more likely to be expressed in a more immediate way via what is described as 'self-injury'. This term has historically been used to describe behaviours such as head banging, eye poking, hand biting or any way in which a child or young person with a learning disability inflicts direct physical harm to themselves. The assessment and interventions related to self-injury are complex and require input from specialist CAMHS staff.

Specialist services for young people over 18 years old

If you work with young people who may need support in adulthood, telephone the Customer Assessment and Advice Team on 01904 555111. They will advise you on the best place to assess a young person's needs. It is important that you involve the young person, their parents/carers and their GP in this process.

Care leavers

If you work with care leavers you will need to contact City of York Council Leaving Care Team. You can email them on pathwayteam@york.gov.uk or telephone them on 01904 555389.

Young people with serious and complex mental health problems and learning disabilities

Tees, Esk and Wear Valleys NHS Foundation Trust provides services for adults who have serious and complex mental health problems and learning disabilities. Referrals to secondary mental health services are made via a single point of access. Contact details are as follows:

Peppermill Court, Ramsay Close,
York YO31 8SS
Tel: 01904 610700

Young people with learning disabilities can access support from the Community Team for People with Learning Disabilities. Their contact details are as follows:

Systems House
Amy Johnson Way, Clifton Moor,
York YO30 4XT
Tel: 01904 528300

Access to these services is dependent on a number of criteria that will be explained when making a referral.

Out of hours: Crisis referrals to Adult Services for young people with mental health needs and for young people with a learning disability and mental health needs should be made via Peppermill Court.

Crisis Service
Peppermill Court, Ramsay Close,
York YO31 8SS
Tel: 01904 610700

Referrals

Single point of access (SPA)

York and Selby Child and Adolescent Mental Health Services are providing a single point of access for children and young people referrals.

The single point of access has been introduced to: simplify access for referrals and service users; allow the service to work to a single operating model; make best use of our expertise; and ensure that the needs of service users are met by the most appropriate service.

The single point of access aims to provide:

- advice prior to referral
- an initial response to young people/ parents/carers within 24 hours
- a 30 minute telephone assessment for all routine referrals
- a face to face assessment within four weeks of referral
- assessment feedback to service user and referrer within five days
- a four hour response for urgent referrals.

Referrals and requests for advice can be made as follows:

- clinical advice via: 01904 615345
- electronic referrals: tewv. camhsspayorkselby@nhs.net
- postal referrals will still be accepted at:

  Single Point of Access (SPA),
  Lime Trees CAMHS,
  31 Shipton Road,
  York YO30 5RE

The core specialist CAMHS function is to:

- provide assessment and treatment of moderate to severe mental health issues and associated risks in young people under the age of 18 (to 18th birthday)
- acknowledge that all young people may experience distress in reaction to life events, transition or family disharmony but those without a clear mental health component to their presentation can be supported by universal services and targeted services.

Schools may want to discuss individual cases with their school wellbeing worker who will be able to signpost to appropriate services and resources.

Support for a child or young person

If the child or young person is currently known to mental health services, encourage or help them to contact their care worker. If they are not currently receiving support from mental health services, they should be encouraged to talk to their parents, teachers or school wellbeing worker/ school nurse to discuss whether a GP appointment is appropriate.

Support for family or carers

Family members, carers or friends can display a variety of reactions when a child or young person is self-harming or has suicidal thoughts, including fear, disgust, guilt, confusion or anger.

Encourage them to support the child or young person even if they do not understand why they are acting in this way. Parents/carers should not give ultimatums that put pressure on the child or young person to stop self-harming as it may result in them using more dangerous methods or becoming more secretive. Instead they should stay calm, keep an open mind, make time to listen, help them find different, less harmful ways of coping, keep the home environment safe and go with them to get the right help. The reason someone self-harms is to help them cope with very difficult feelings that build up and which they cannot express.

Some people may find it helpful to access support by calling the free and confidential Young Minds parents helpline. Details are available on the following weblink: www.youngminds.org.uk/for_parents/parent_helpline

Some parents may prefer to discuss these issues with the family GP or contact the single point of access directly and may be referred via this route.

Bereaved by suicide

People who have experienced suicide in the family have a higher risk of suicide themselves, so it is important to be aware of this if you are working with children and young people who have been bereaved by suicide.

'Help is at Hand' is a useful resource produced by the Department of Health for people bereaved by suicide and other sudden, traumatic death. It also provides information for healthcare and other professionals who come into contact with bereaved people.

'Help is at Hand': www.nhs.uk/Livewell/Suicide/Documents/Help%20is%20at%20Hand.pdf

City of York Council has also produced two booklets for schools:

- Supporting Bereaved Children and Young People: Guidance for School staff. Published by CYC Educational Psychology Service 2011.
- When Someone Close Dies: Information Booklet for Children and Young People. Published by CYC Educational Psychology Service 2011.

Principles for working with children and young people

Confidentiality/sharing information

Everyone is entitled to confidentiality even if they are under the age of 16. The decision whether to share the information depends on the degree of current or potential harm, it does not depend on the age of the child or young person. Remember to let the child or young person know your confidentiality processes.

Sometimes concerns of significant harm may lead you to make a referral or share information with their GP without consent, however it is highly recommended to seek consent where possible. Seeking consent should not delay any urgent action required. Seek support from your manager for this process.

All professionals working with young people have to be accountable if they decide to share information and break confidentiality by showing that the decision was in the child or young person's best interest. If this happens, a child or young person can expect to be:

- told that the information is being shared, with whom and why
- kept informed, and
- offered appropriate support.

Ensure that you record any discussions or actions related to self-harm or suicidal intent in line with your organisational policies.

If the level of self-harm poses a risk to the child or young person's health or wellbeing, or if they are considering suicide, it is always necessary to talk to them, and share information with other agencies including their GP, Children's Social Care, teacher, key worker and parents/carers. Some children and young people may feel concerned at parents being notified, so explore the underlying reasons for this before you decide whether to proceed. In cases of an abusive home life it may not be

in their best interest to inform parents as it may increase the risk to the child or young person. You should seek the child or young person's views on what should happen next and discuss the reasons for sharing information. Reassure them that they will be supported throughout the process.

If you do not feel that the child or young person is at serious risk, it is still advised to encourage them to allow you to share information with their GP to promote continuity of care. However, their right to confidentiality should be respected if they do not want you to do so. Similarly it is good practice to encourage the child or young person to draw on the support of parent/carers if appropriate.

Remember to use the questions outlined on pages 13–16 and the high risk warning signs on pages 8–12 to help you with your decision.

Competency

Fraser Guidelines and Gillick Competence[2] and the Mental Capacity Act[3] outline important principles to help assess whether the child has the maturity to make their own decisions and understands the implications of those decisions. In assessing competence you need to ensure that they can understand the information and advice that you are giving them.

If a child or young person is judged as not competent and does not understand their situation, you will need to work sensitively in order to break their confidence. Inform them of your requirement to do this, how this will be done and what is expected to happen. Your aim is to ensure that they are safe and have access to any help which is required.

[2] www.nspcc.org.uk/preventing-abuse/child-protection-system/legal-definition-child-rights-law/gillick-competency-fraser-guidelines/

[3] www.gov.uk/government/collections/mental-capacity-act-making-decisions

National support/helplines

Organisation	Service	Telephone	Website
ChildLine	Free and confidential helpline for children and young people.	0800 11 11	www.childline.org.uk/pages/home.aspx www.childline.org.uk/selfharm
HOPELineUK	A specialist helpline staffed by trained professionals who give non-judgemental support, practical advice and information to: • children, teenagers and young people up to the age of 35 who are worried about themselves. • anyone who is concerned about a child or young person.	0800 068 41 41	www.selfinjurysupport.org.uk/group/papyrus-hopelineuk/
Learning Disability Helpline	Provides information and advice.	0808 808 1111	www.mencap.org.uk/mencap-direct
MindEd	A free online portal is available to help staff learn about mental health issues, as well as signposting them to resources.		www.minded.org.uk
MIND Infoline	Whether you are living with a mental health problem, or supporting someone who is, having access to the right information – about a condition, treatment options, or practical issues – is vital.	0300 123 3393	www.mind.org.uk
National CAMHS Support Service	National Workforce Programme – Self-harm in Children & Young People Handbook.		healthyyoungmindspennine.nhs.uk/resource-centre/guides/self-harm-in-children-and-young-people-handbook/
National Self Harm Network	National Self Harm Network offers an online moderated support forum for people affected by self-harm.		www.nshn.co.uk
Samaritans	Confidential helpline.	116 123 (24 hours – free to call)	www.samaritans.org/

Organisation	Service	Telephone	Website
Stay Alive App	The 'Stay Alive' app is free to download. It is part of the Grassroots Suicide Prevention work which looks to teach suicide alertness and intervention skills to community members and professionals. To download the Stay Alive app search 'Stay Alive' on the App Store or Google Play.		www.prevent-suicide.org.uk/stay_alive_suicide_prevention_mobile_phone_application.html
STEM4 Website	Teenage mental health advice and new 'App' for self-harming teenagers. A charity organisation which provides advice for teenagers, parents, schools and health professionals, as well as advice regarding school policies.		STEM4.org
The National Autistic Society	If you are living with Autism as a child, an adult or as a family, we provide specialist help, information and care across England. Our local services include our residential homes, one-to-one support, support in your home, day-time hubs and support in further and higher education.		www.autism.org.uk/
'You are not Alone'	A new Guide for Parents who are coping with their child's self-harm.		www.psych.ox.ac.uk/news/new-guide-for-parents-who-are-coping-with-their-child2019s-self-harm-2018you-are-not-alone2019
Young Minds Parents Helpline	A free and confidential national helpline for parents.	0808 802 5544 (9.30am – 4pm Monday to Friday)	www.youngminds.org.uk/

Local support – useful websites

www.healthwatchyork.co.uk/

The new edition of the Healthwatch guide to Mental Health and Wellbeing in York is now available to view: www.healthwatchyork.co.uk/wp-content/uploads/2014/06/Guide-to-Mental-Health-and-Wellbeing-in-York-issue-2.pdf

This booklet has been produced by York's Strategic Partnership, Emotional & Mental Health (Children & Young People).

It has drawn on the following documents:

- Leeds Local Authority Self-harm and Suicidal Behaviour publication from Leeds Public Health, Leeds Clinical Commissioning Groups and Leeds LSCB (2013).
- North Yorkshire Local Authority Self-harm and Suicide Behaviour Book (2016).
- North Yorkshire Guidance on Self Harming for Schools and Pupil Referral Services.
- Children's Trust Partnership Hertfordshire (2010). Self- harm and Suicidal Behaviour: A Guide for Staff working with Children and Young People in Hertfordshire.
- Mental Health Foundation (2006): Truth Hurts: Report of the National Enquiry into Self-harm among Young People. Fact or Fiction?
- National Institute for Health and Clinical Excellence (NICE) (2011). Self-harm longer-term management.
- National Collaborating Centre for Mental Health (2004). Self-harm: The Short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care. National Clinical Practice Guideline Number 16.

Appendix A

Training opportunities

Some of the training opportunities available:

- ASIST - Applied Suicide Prevention Skills Training, which is a two day course.
- 'Safetalk', a three hour input, introduces delegates to the difficult/sensitive area of conversations with someone who may be at risk. Both these courses were developed by The Living Works Foundation in Canada and are delivered by accredited trainers all over the world – www.livingworks.net/
- Mental Health First Aid – a national accredited course: www.mhfaengland.org/

You may also wish to explore the availability of training within your own organisation.

Contact Workforce Development Unit (WDU)

Colleagues can book through WDU by email: wdu@york.gov.uk
Or by contacting a member of the team on: 01904 553017.

Contact Pathfinder

Schools can book through Pathfinder:
www.pathfinder-education.co.uk/cpd-and-succession-planning/mental-health/

Appendix B

The CAMHS Executive has been refreshed to create:

- a new core group – The Strategic Partnership, Emotional & Mental Health (Children & Young People) – SPEMH
- seven sub-groups.

Strategic Partnership, Emotional & Mental Health (Children & Young People)

Sub-group 3
Children Looked After (CLA) Emotional Wellbeing and Mental Health Support Sub-group

Child & Adolescent Mental Health Service; CLA Group Managers; Clinical Commissioning Group; Designated Doctor; Educational Psychology Service; FIRST; Foster Carers; Virtual Headteacher.

Chair: Sophie Keeble/Gwynne Rayns

Sub-group 4
Risk Support Sub-group

Child & Adolescent Mental Health Service; Danesgate, Howe Hill Hostel; NHS Acute Trust; North Yorkshire Police, Public Health; Schools, Voluntary Sector; Youth Offending Service.

Chair: Carol Redmond

Sub-group 5
Transitions Sub-group

Adult Mental Health Service, Adult Social Care; Child & Adolescent Mental Health Service; Further & Higher Education; Housing; Public Health; Transitions Team.

Chair: Graeme Murdoch

Sub-group 2
Accessing Emotional & Mental Health Support Sub-group

Child & Adolescent Mental Health Service; Local Area Teams; Pathway Service; Schools, School Wellbeing Service; Voluntary Sector.

Chair: Niall McVicar

Strategic Partnership, Emotional & Mental Health (Children & Young People)

Sub-group 6
Participation Sub-group

Adult Mental Health Service; Child & Adolescent Mental Health Service; Clinical Commissioning Group; GPs; Speak Up Service; Voluntary Sector; Youth Council.

Chair: Niall McVicar

Sub-group 1
Early Intervention Sub-group

Child & Adolescent Mental Health Service; Clinical Commissioning Group; Education Psychology Service; Local Area Teams; Public Health, Schools; School Wellbeing Service; Voluntary Sector.

Chair: John Tomsett

Sub-group 7
Training & Workforce Development Sub-group

Child & Adolescent Mental Health Service; Children's Social Care; Clinical Commissioning Group; Danesgate, Education Psychology Service; Higher Education; NHS Acute Trust; Pathfinder MAT; Public Health; Schools; School Wellbeing Service; Virtual Headteacher; Voluntary Sector; Workforce Development Unit.

Chair: William Shaw

ANNEX 3

CITY OF YORK COUNCIL

If you would like this information in larger print or in an accessible format (for example, in Braille, on CD or by email), please telephone 01904 554212.

This information can be provided in your own language.

Informacje te mogą być przekazywane w języku ojczystym.
Polish

Bu bilgi kendi dilinizde almaniz mümkündür.
Turkish

此信息可以在您自己的语言。
Chinese (S molified)

此資訊可以提供您自己的語言。
Chinese (Traditional)

01904 551550

14 November 2018

Health, Housing & Adult Social Care Policy & Scrutiny Committee

Report of the Director of Public Health

Update on Oral Health in the City of York

Summary

1. A previous performance report to Scrutiny highlighted that hospital admissions for dental caries for children aged 0-4 in York were higher than the England average.

2. The Scrutiny Committee requested that further work be carried out to understand the reasons for this and what recommendations might be needed to improve this.

3. This report outlines the aims of the Oral Health Improvement Advisory Group (OHIAG) that has been established to undertake this work and to update the committee of the work undertaken by the group so far.

Background

4. An Oral Health Improvement Advisory Group (OHIAG) was established for York in December 2017. The main purpose of the OHIAG was to bring partners together from across the City of York to drive oral health improvement and address oral health inequalities.

5. The group would also look to promote population oral health prevention across the city. The OHIAG will use relevant data to inform decision making and prioritise goals. The group provides a forum to highlight any population based oral health concerns within York.

6. The OHIAG identified their first priority as being children. This was in response to the Joint Health and Wellbeing Strategy for York, which stated the Board would monitor progress on 'reducing hospital admissions for tooth decay in children' and in response to the request from this Scrutiny Committee to have a better understanding

of the reasons for high admissions for dental caries in the 0-4 age group and develop an action plan to address this.

7. To achieve the aims and objectives of the group, membership constitutes representatives from a wide range of organisations with a particular interest and focus on oral health in the City of York. These include:

    - Public Health Lead, City of York Council
    - Members of the Local Dental Committee
    - Local Dental Network Chair and Dental Commissioner, NHS England
    - Clinical Director, Salaried Dental Service
    - Consultant in Dental Public Health, Public Health England
    - Specialist Registrar in Dental Public Health, Public Health England
    - Representative of Dental Care Professionals
    - Oral Health Promotion leads
    - Patient Representative: Healthwatch
    - CCG representative
    - Acute NHS trust
    - CYC – Representation from the Healthy Child Service and Adult Social Care
    - As the group develops the membership list is anticipated to expand.

8. An oral health needs assessment of children in York is being undertaken by OHIAG. This is exploring the oral health needs and oral healthcare needs of children in York to identify any areas of concern in order to target resources towards improving the oral health of those at specific risk. The needs assessment had a specific aim of understanding the high admission rates for dental caries in 0-4 year olds in York.

9. The needs assessment is not yet finalised, but the data that has been examined to date has given a better understanding of the oral health of the children of York. It has included looking at the national oral health survey of 5 year old children in England, which is conducted every 2 years. The latest survey conducted in the 2016/17 school year revealed that 84.1% of 5 year old children in York that were surveyed (n=273) had no experience of dental decay. York had the highest percentage of 5 year olds with no experience of dental decay compared with all other areas of Yorkshire and the Humber that participated in the survey.

10. A Healthwatch report ‘Filled to Capacity: NHS Dentistry in York’ published in March 2018 reported the experiences of the local

population in York in accessing NHS dental care. The report explored the challenges facing individuals in accessing NHS dental care within the city. The needs assessment considered the issue of access for children and found that recent data provided by NHS England showed that between 82 and 93% of children aged 3-17 years of age in York in 2016/17 attended an NHS dental practice with slightly lower figures for 2017/18 (ranging from between 81-91%).

11. For all age groups between 0-17 years of age, attendance at an NHS dental practice in York was better in 2016/17 and 2017/18 when compared with attendance regionally in Yorkshire and the Humber.

12. Despite NHS dental attendance for children in York aged 0-2 years being higher than regional reported data, access for this age group is low at 38% for 2016/17 and 2017/18.

13. Professional application of fluoride varnish two or more times per year has been shown to be effective in reducing the levels of dental decay in both the primary and permanent dentition. Data supplied by NHS England reveals that 53.5% of children aged between 0-17 years of age received a Fluoride varnish application in 2016/17 and this increased to 64% in 2017/18. The numbers of applications has increased in York for children from 12620 applications in 2013/14 to 24713 in 2017/18.

14. The latest Hospital Episode Statistics (HES) from Public Health England for 2016/17 reveal that finished consultant episodes in York, by percentage of population, for all extractions, (for all diagnoses) in a hospital setting was the same as that for England for 0-19 year old children as a whole (0.5%), as well as for those aged 10-14 years of age (0.5%) and 15-19 years of age (0.3%). Comparing York with a Yorkshire and Humber NHS footprint for the same statistic for 0-19 year olds, a smaller percentage of the population of York was affected (0.8% Yorkshire and Humber compared with 0.5% York).

15. For children aged 0-4 years of age and 5-9 years of age, York had a higher percentage of the population than England (0-4 years of age - 0.5% York, compared with 0.3% England) and for those aged 5-9 years of age (1% York, compared with 0.8% England). York was the same or better though when compared regionally for those age groups 0-4 years of age (0.5% York 0.5% Yorkshire and Humber), 5-9 years of age (1% York compared with 1.5% Yorkshire and the Humber), 10-14 years of age (0.5% York compared with 0.6%

Yorkshire and the Humber), 15-19 years of age (0.3% York with 0.3% Yorkshire and the Humber).

16. In 2016/17 the percentage of finished consultant episodes for extractions with caries (dental decay) as the primary diagnosis was 67.9% in York compared with 63.6% for England. NHS England is currently exploring services performing dental extractions under general anaesthesia across the Yorkshire and Humber region as a whole. Due to the nature by which dental data is currently collated by the NHS, the latest data supplied by NHS England in relation to referrals to the Community Dental Service is on a Trust level geography and numbers of dental procedures performed in a hospital environment (including dental extractions under general anaesthesia) is on a Vale of York CCG footprint. It is not possible from either of these datasets to accurately assess whether there is an increased need for this service from residents within the city of York at present.

Consultation

17. The oral health needs assessment for children is being progressed through the OHIAG, membership of which has been outlined in paragraph seven above.

Analysis

18. Although the oral health needs assessment has not been finalised as yet, the data examined to date is showing an emerging picture of the oral health of our children in York. It suggests that in five year olds in York oral health is good. There is data that suggests that oral health by age 12 has declined, but this data is almost ten years old.

19. Attendance at a dentist for young people in York is high, although improvements could be made in the 0-2 age group. This is likely to be achieved through better education of parents about when to start taking your child to see a dentist.

20. The number of children in York receiving fluoride varnish is increasing, but further improvements in this could be achieved.

21. Referral to hospital for tooth extractions for any cause is in line with England rates overall for children in York, although it is slightly higher for the under 10 age groups. This is not a dissimilar picture to that seen for the Yorkshire and Humber region as a whole.

22. The high rates of extractions under general anaesthesia for dental caries in the 0-4 age group has not fully been explained to date, but

the data highlighted suggests that this is not due to poorer oral health of children in York.

Council Plan

23. The work of the OHIAG relate to the Council Plan priority to focus on frontline services for residents.

Implications

Financial - There are no financial implications to this report. The OHIAG is undertaken within the budget of Public Health.

Human Resources (HR) - There are no HR implications

Equalities - The aim of the OHIAG is to improve oral health for all residents of the City of York.

Legal - There are no legal implications

Information Technology (IT) - There are no IT issues relating to this report

Property - There are no property issues relating to this report

Risk management - The recommendations within this report do not present any risks which need to be monitored.

Recommendations

24. The Committee are asked to:

i. Receive the update on the work being carried out to understand the oral health of children in York.
ii. Agree to receive the final version of the oral health in children needs assessment when it is finalised in December 2018.
iii. Agree to receive an Oral Health Strategy for York, when produced in 2019.
iv. Consider inviting NHS England to report to scrutiny on the work they are undertaking on tooth extractions under anaesthesia across the region.

Reason: To keep the committee informed of issues relating to the oral health of children in York and provide assurance that action is being taken to address any areas where concerns are raised.

Contact Details:

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Chief Officer Responsible for the report:

Sharon Stoltz
Director of Public Health

Report Approved	✓	**Date**

Wards Affected: **All** ✓

For further information please contact the author of the report

Abbreviations

CCG- Clinical Commissioning Group
CYC – City of York Council
HES - Hospital Episode Statistics
NHS- National Health Service
OHIAG - Oral Health Improvement Advisory Group

Health, Housing and Adult Social Care Policy and Scrutiny Committee

Work Plan 2018-19

20 June 2018 @ 5.30pm	**Housing** 1. Attendance of Executive Member for Housing and Safer Neighbourhoods **Health** 2. Business case for new mental health hospital for York 3. CCG report on Patient Transport Services for York 4. Unity Health Report on patient communication problems 5. Report on sexual health re-procurement. 6. Scoping report on Commissioned Substance Misuse Services 7. Work Plan 2018-19
25 July 2018 @ 5.30pm	**Health** 1. Attendance of Executive Member for Health and Adult Social Care 2. HWBB Annual Report including review of Health and Wellbeing Strategy and update on new Mental Health Strategy 3. End of Year Finance and Performance Monitoring Report 4. Six-monthly Quality Monitoring Report – residential, nursing and homecare services 5. Safeguarding Vulnerable Adults Annual Assurance Report 6. Work Plan 2018-19

11 Sept 2018 @ 5.30pm	1. 1st Quarter Finance and Performance Monitoring report **Health** 2. Update on Unity Health Actions to improve patient communications and CQC inspection. 3. Update report on Priory Medical Group proposals to relocate to proposed Burnholme Health Centre 4. Update Report on Elderly Persons' Accommodation 5. Delivery of CQC Local System Review Action Plan 6. Substance Misuse Services Scrutiny Review Update Report 7. Work Plan 2018-19
16 Oct 2018 @ 5.30pm	**Housing & Community Safety** 1. Safer York Partnership Bi-annual Report 2. Update on Community Policing – Lindsey Robson, York, Selby Commander 3. Update report on implementation of new licensing laws for HMOs 4. Work Plan 2018-19
14 Nov 2018 @ 5.30pm	**Health** 1. Mental Health Help Line 2. Report on engagement around Home First Strategy 3. Healthwatch York six-monthly Performance Report

	4. Overview report on self-harm and suicide prevention 5. Report on aims of Oral Health Action Team 6. Work Plan 2018-19
12 Dec 2018 @ 5.30pm	1. HWBB six-monthly update report 2. Update Report on progress of CYC Asset/Place-based approach to working. (Pippa Corner / Joe Micheli) 3. CCG Chair Dr Nigel Wells, Introduction and Update on Elective Criteria Policy 4. Work Plan 2018-19
15 Jan 2019 @ 5.30pm	1. 2nd Quarter Finance and Performance Monitoring Report **Health** 2. Update Report on Unity Health 3. Overview report on student health services 4. Update report on Priory Medical Group proposals to relocate to proposed Burnholme Health Centre (TBC depending on funding agreements) 5. Six-monthly Quality Monitoring Report – residential, nursing and homecare services 6. Work Plan 2018-19
12 Feb 2019 @ 5.30pm	1. Work Plan 2018-19
12 March 2019 @ 5.30pm	1. 3rd Quarter Finance and Performance Monitoring Report **Health**

	2. Healthwatch York six-monthly Performance Report **Housing** 3. Safer York Partnership Bi-Annual report 4. Draft Work Plan 2019-20