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17 January 2024

West Sussex Health and Wellbeing Board

A meeting of the Committee will be held at **10.30 am** on **Thursday, 25 January 2024** at **County Hall, Chichester, PO19 1RQ**.

The meeting will be available to watch live via the Internet at this address:

http://www.westsussex.public-i.tv/core/portal/home.

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Agenda

10.30 am 1. **Chairman's Welcome**

10.40 am 2. **Declaration of Interests**

Members and officers must declare any pecuniary or personal interest in any business on the agenda. They should also make declarations at any stage such an interest becomes apparent during the meeting. Consideration should be given to leaving the meeting if the nature of the interest warrants it; if in doubt contact Democratic Services before the meeting.

3. **Urgent Matters**

Items not on the agenda that the Chairman of the Board is of the opinion should be considered as a matter of urgency by reason of special circumstances.

4. **Minutes** (Pages 5 - 14)

The Board is asked to confirm the minutes of the meeting of the Health and Wellbeing Board held on 20 July 2023.

10.45 am 5. **Actions and Recommendations Tracker** (Pages 15 - 24)

The Board is asked to monitor/note the responses to Recommendations and Actions made at the meeting on 20 July 2023.

10.55 am 6. **West Sussex Safeguarding Children's Partnership Annual Report** (Pages 25 - 28)

The West Sussex Safeguarding Children's Partnership (WSSCP) is required to produce an annual report providing an overview of its key achievements against its business plan priorities. The Health and Wellbeing Board does not have a role in approving or endorsing this annual report as it is a partnership document. It will be presented to the board, for information, as a key partner and as WSSCP activities aligns with the Joint Health and Wellbeing Strategy outcomes.

11.05 am 7. **Public Health Update**

The Director of Public Health will provide a verbal update on current public health matters.

11.15 am 8. **West Sussex Suicide Prevention Framework and Action Plan 2023-2027, and Sussex Suicide Prevention Strategy and Action Plan 2024-2027** (Pages 29 - 118)

Following the progress update presented to the Health and Wellbeing Board on 27 April 2023, this report presents the final West Sussex Suicide Prevention Framework and Action Plan 2023 – 2027 (including Year 1 action plan to April 2024), and the Sussex Suicide Prevention Strategy and Action Plan 2024 - 2027.

11.35 am 9. **Developing a strategic approach to food and nutrition across West Sussex** (Pages 119 - 142)

This report and presentation will set out the intention and need to develop a strategic approach to food and nutrition for all ages across West Sussex.

11.45 am 10. **Better Care Fund** (Pages 143 - 158)

This paper provides an update on Better Care Fund (BCF) Planning for 2023-25, presents the Better Care Fund Q3 Quarterly Report for approval and the Q2 Quarterly Report for information, and summarises performance against the Better Care Fund national metrics for Quarter 2 2023-24.

12.00 pm 11. **Sussex Integrated Care System Verbal Update**

Pennie Ford, Executive Managing Director NHS Sussex and Chris Clark, WSCC Assistant Director (Health Integration) and Joint Strategic Director of Commissioning (West Sussex) NHS Sussex Integrated Care Board will provide a brief verbal update.

12.10 pm 12. **Health & Wellbeing Board Work Programme 2023-24**
(Pages 159 - 164)

To note the work programme for 2023/24 as attached. Members of the Board are requested to mention any items which they believe to be of relevance to the business of the Health and Wellbeing Board. If any member puts forward an item the Board is asked to assess briefly whether to refer the matter to the Chairman to consider in detail for future inclusion.

12.15 pm 13. **Date of next Meeting**

The next meeting of the Board will be held at 10.30am on 25 April 2024.

To all members of the West Sussex Health and Wellbeing Board

Webcasting

Please note: this meeting is being filmed for live and subsequent broadcast via the County Council's website on the internet. The images and sound recording may be used for training purposes by the Council.

Generally the public gallery is not filmed. However, by entering the meeting room and using the public seating area you are consenting to being filmed and to the possible use of those images and sound recordings for webcasting and/or training purposes.

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West Sussex Health and Wellbeing Board

20 July 2023 – At a meeting of the West Sussex Health and Wellbeing Board held at 10.30 am at County Hall, Chichester, PO19 1RQ.

Present: Cllr Bob Lanzer (Chairman)
Cllr Amanda Jupp, Cllr Jacquie Russell, Cllr Garry Wall, Alan Sinclair, Alison Challenger, Lucy Butler, Emily King, Chris Clark, Pennie Ford, Natalie Brahma-Pearl, Catherine Howe, Jess Sumner, Sonia Mangan, Emma Cross and Annie Callanan

Apologies: Dr George Findlay, Siobhan Melia, Jo Tuck and Dr Jane Padmore

Absent: Dr A Dissanayake and Dr Angela Stevenson

Also in attendance: Ellie Evans

Part I

1. Chairman's Welcome

1.1 The Chairman welcomed attendees and those viewing the webcast to the meeting. It was announced that Natalie Brahma-Pearl, the Chief Executive of Crawley Borough Council, was standing down as a board member. The Chairman thanked Natalie for her many years of valuable service, as a member of the West Sussex Health and Wellbeing Board, which had been greatly appreciated and wished her well in her future endeavours.

1.2 The Chairman then outlined the following updates;

- it was reported that Sussex health and care partners launched **'Our Plan for our Population'** on the 75th anniversary of the NHS, following ratification by the NHS Sussex Board on 5 July 2023. This was noted as the first time there has been an agreed long-term plan across health and care in Sussex. The draft plan was presented at the Health and Wellbeing Board meeting in April, with a large number of comments shared with the NHS following this, helping to shape the final version. The plan was also presented to the Health and Adult Social Care Scrutiny Committee (HASC) on 14 June and supported by the Council's Cabinet on 20 June. The Health and Wellbeing Board recognised that the plan is ambitious, particularly as it is for the whole of Sussex. However, the place of West Sussex, has a place in this plan, setting out how we will deliver services to meet our population's needs across the county;

- on Saturday 1 July, the grand opening of the **new town centre location of the Horsham Wellbeing Hub** took place. Located in the heart of Horsham town in Unit 51, Swan Walk shopping centre it will enable more residents to access support tailored to their own needs and situation, make positive changes to their habits, and

support them to stay well. Anyone over 18 who lives or works in the Horsham District can access a wide range of free information, advice and support at the hub, and discover how a few small changes to their health and wellbeing routines can make big differences to their lives. The Hub builds upon a long-standing partnership between West Sussex County Council and Horsham District Council to improve the health of local residents and reduce inequalities, as part of the West Sussex Wellbeing Programme - a partnership with all district and borough councils across West Sussex. Further information is available on the Horsham District Wellbeing website; and

- The **Notice of Motion at Full Council on 26 May regarding defibrillators was carried**. This focused on increasing access to the devices in communities and registering them on the British Heart Foundation's National Defibrillator Network, 'The Circuit', which provides NHS ambulance services with information regarding defibrillators across the UK, so they can be accessed quickly after a cardiac arrest, to help save lives. Utilising this network, a 999 operator may be able to signpost to the nearest defibrillator, if needed in an emergency. The Chairman informed the Board that as the Cabinet Member for Public Health and Wellbeing, he was working closely with his Cabinet colleagues as part of a cross-council approach, to progress actions that included relocating defibrillators, maintained by the County Council's Facilities Management team, to external locations that are accessible 24/7 to the public and arranging for them to be registered on 'The Circuit.' Further planned actions comprised of engagement with schools and communities to widen the publicly accessible defibrillator network across West Sussex, including highlighting to residents and communities the governments recently launched £1m defibrillator fund to which community organisations can submit an expression of interest.

2. Declaration of Interests

2.1 There were no declarations of interest.

3. Minutes

3.1 In receiving the minutes of the last meeting taken on 27 April 2023, comment was made that the recommendations at minute 59.4 required amendment to add a third recommendation. It was agreed that the Health and Wellbeing Board Seminar, held on 20 February 2023, suggested the exploration of the use of One Public Estate properties for housing use. As the Strategic Housing Group would not hold the jurisdiction to progress the use of these assets for social value purposes recommendations were amended as follows;

3.2 The Health and Wellbeing Board resolved that;

i. housing and environments be continued as ongoing key priorities in the refreshed Joint Health and Wellbeing Strategy from 2024;

ii. the use of One Public Estate properties for housing provision be explored and reported back on; and

iii. the West Sussex Strategic Housing Group be asked to take forward the key actions identified at the seminar, working collaboratively with stakeholders and partners across the county's health and social care system, providing a progress update to the Health and Wellbeing Board during 2023/2024.

3.3 Following this amendment, it was resolved – that the minutes of the meeting held on 27 April 2023, are approved as a correct record and are signed by the Chairman.

4. Recommendations and Actions Tracker

4.1 The Board considered the Recommendations and Actions Tracker (copy appended to the agenda available on the council's website) which had been updated from the last meeting on 27 April 2023. The Chairman asked Board Members to note the Chairman's Action that had been taken to approve the Better Care Fund End of Year Return (2022/23).

5. Public Forum

5.1 The Chairman informed the Board that three questions had been received from West Sussex residents. One asked why there are no more exercise classes for the senior people at the sheltered schemes in Crawley and felt that Crawley needed a hub office like Horsham as there are so many empty shops around Crawley including the shopping mall.

5.2 The Chairman responded to the enquirer as follows; 'To provide some context, Board members will be aware that Horsham District Wellbeing, part of the West Sussex Wellbeing Programme, recently launched its new town centre location in Swan Walk shopping centre, Horsham, providing access to a wide range of health and wellbeing information, advice and support.

5.3 Crawley Wellbeing, also part of the West Sussex Wellbeing Programme, is based at the K2 Leisure in Crawley, and in March this year, launched the Wellbeing Mobile Unit, which visits different neighbourhoods in Crawley, making its' services more accessible for our residents and communities. Today it is in Queens Square, Crawley, with appointments available for a range of health and wellbeing issues. If residents would like further information, please visit the Crawley Wellbeing website at crawley.westsussexwellbeing.org.uk

5.4 In addition to the Mobile Wellbeing Unit and provision at K2, Wellbeing staff signpost to a variety of physical activity provision within Crawley and surrounding areas to suit all abilities. More information can be found on the Crawley Wellbeing website or by calling Crawley Wellbeing on 01293 585317. The Crawley Older Peoples Directory is an additional useful resource (produced jointly

by Crawley Wellbeing, Crawley Community and Voluntary Service (CVS) and Crawley Borough Council), which includes helpful information regarding local exercise classes and other services.

5.5 Residents, or anyone who works in West Sussex, can access any of the wellbeing programmes based in each district and borough, further information on what's available can be found at www.westsussexwellbeing.org.uk `

The Chairman confirmed that a full written response would also be sent to the enquirer following this meeting. The Chairman informed that a further question had been received from West Sussex County Councillor, Brenda Burgess regarding improving joining-up information between health care services, ensuring the patient remains informed throughout their healthcare journey, and the importance of the patients' voice. The Chairman thanked Councillor Brenda Burgess for raising this and confirmed a written response would be provided.

5.6 The Chairman had been informed, today, that a further question had been submitted, via Facebook, on the provision of exercise classes in sheltered housing. It was noted that a response would be prepared outside of the meeting.

6. Children First Board

6.1 The Director of Children, Young People and Learning presented the report on the progress of the Children First Board (CFB), being accountable to the West Sussex Health and Wellbeing Board, as a subgroup of the Board.

6.2 It was noted that governance arrangements were being reviewed with respect to children with special educational needs and disabilities. An inspection by OFTED and CQC was expected. The Director of Children, Young People and Learning requested that the Health and Wellbeing Board received a report from the SEND Governance Board on a six monthly basis. The Chairman agreed this request.

6.3 In being invited to comment, Cllr Jaquie Russell, as a member of the Board and as Cabinet Member for Children, Young People and Learning highlighted that, as part of a review of governance arrangements, the CFB were in the process of securing an independent chair: a role profile had been created and Officers were currently working with colleagues in the voluntary and community sector to recruit a suitable candidate. Attention was also drawn to the focus on CFB engagement with its stakeholders as well as the continued priority of engagement with children and young people.

6.4 The Chairman thanked the Director of Children, Young People and Learning for this report.

7. Public Health Update

7.1 The Director of Public Health's update to the Health and Wellbeing Board on current public health matters, focused on the issue of vaping, which has received recent media attention and consideration.

7.2 In clarifying key messages, the Director of Public Health highlighted Sir Professor Chris Whitty's recent statement – three key areas, with the main message being, if you smoke, vaping is going to be substantially safer *[full Sir Prof Chris Whitty quote: "The key points about vaping (e-cigarettes) can be easily summarised. If you smoke, vaping is much safer; if you don't smoke, don't vape; marketing vapes to children is utterly unacceptable"].* She emphasised that smoking is still one of the key reasons for avoidable ill-health; vaping is an effective quitting tool and is substantially safer than continuing to smoke cigarettes.

7.3 The exposure and promotion of vaping to young people, and particularly some disposable vapes, is a concern, and has recently been in the media. The environmental impact is another element to consider. Whilst the Local Government Association (LGA) has called for a ban on disposable vapes, it was recognised that this is one step and there are other approaches too, but we are all joined up in our key ambition to try and reduce exposure of vaping to our young people. It was noted that Public Health are working with the Council's Trading Standards service, across our local health and care system, with members of our communities, and nationally and regionally to tackle these issues.

7.4 The local Public Health response would continue whilst waiting for national guidance. It was highlighted resources had been developed for schools (to be released in September) by the South East Public Health Tobacco Control Network, and the Department of Health and Social Care had produced a national resource pack focused on Years 7 and 8. The Director of Public Health confirmed that West Sussex schools had been written to, to inform them, with a surgery/discussion seminar offered to support them in their approach in September.

7.5 In discussion, a multi-agency task force/forum was suggested to include the Voluntary, Community and Social Enterprise (VCSE) sector, connecting with communities, and a focus on climate and environmental issues of disposable vapes to young people, to deter them from vaping.

8. West Sussex Safeguarding Adults Board Annual Report 2022-2023

8.1 The Board received the West Sussex Safeguarding Adults Board (WSSAB) Annual Report for 2022-23 (copy appended to the agenda available on the council's website) presented by Annie Callanan, Independent Chairman of the West Sussex Safeguarding Adults Board and Ellie Evans, Adults Social Care Assistant Director

Safeguarding, Planning and Performance for West Sussex County Council. The following key points were highlighted;

- It was noted that the report reflected progress on the priorities for 2022/23: safeguarding older people, safeguarding those with complex needs, and communications and promotions for community engagement. The Independent Chairman praised and thanked WSSAB members for their high levels of commitment, and the benefit of their expertise.
- It was reported that real progress has been made on the WSSAB work programme with high levels of engagement from all of the Board Members who were willing to have frank discussion as well as embracing research to aid the Board's continued development. The Independent Chairman was pleased to welcome two lay persons onto the WSSAB.
- The WSSAB had progressed a number of reviews, increasing the involvement of carers and their families ensuring action plans were delivered. It was noted that the adult reviews were an opportunity to learn and avoided laying blame.
- It was reported that in order to share learning widely and effectively all reviews were published with accompanying learning briefings and a multi-agency action planning meeting for each one was held to agree how both individually and collectively safeguarding practice would be improved. This method ensured multi-agency ownership and accountability for the changes that are needed to reduce safeguarding risk.

8.2 In discussing this report Health and Wellbeing Board Members;

- praised the WSSAB for a comprehensive report which recorded achievements as well as raising awareness and thanked the Independent Chairman and the Adults Social Care Assistant Director Safeguarding, Planning and Performance for the Board's strong position;
- noted that learning was being shared with partners such as Changing Futures, influencing and supporting strong engagement;
- recognised that Adult Social Care was challenged in terms of people needing support for a range of conditions and so a good WSSAB with effective procedures was welcomed;
- reminded that the CQC would be inspecting West Sussex Adult Social Care for the first time and safeguarding would be a key element of this;
- shared that research was key so that the WSSAB could develop learning to achieve a trauma based understanding of people's lives. The WSSAB were working pan Sussex with partners to understand lived experience and had introduced a thematic review of the repeating theme of neglect to identify why it keeps repeating and what the challenges are.
- commented that the NHS was starting a new strand of work around population frailty, with the knowledge that people suffering from neglect/self-neglect may be high service users, and welcomed join up with the WSSAB;

- acknowledged the Cost of Living's possible impact on the health of the vulnerable and suggested that a systems approach to making connections be extended to include District and Borough Councils who may not always be sighted on vulnerable residents. It was also mentioned that there was an opportunity to work with the Voluntary Sector Food Banks to share live data. It was confirmed that the WSSAB would be happy to explore these ideas;
- reassured that community connections were being made with the support of the West Sussex County Council Assistant Director (Communities) and the Community Support Team;
- thanked the WSSAB for including carers/family/friends in the annual report, noting that every WSSAB meeting begins with a case study, sometimes hearing from front line services, which helped to anchor the focus where it needs to be.

8.3 The Chairman thanked Annie Callanan, Independent Chairman of the West Sussex Safeguarding Adults Board and Ellie Evans, Adults Social Care Assistant Director Safeguarding, Planning and Performance for the WSSAB Annual Report 2022/23.

8.4 Resolved – that the West Sussex Health and Wellbeing Board;

i. actively supports the WSSAB's strategic plan to improve prevention services and the experience of adults in West Sussex County Council who are at risk of abuse and/or neglect;

ii. has provided feedback on how the Health and Wellbeing Board, as representative of the partner agencies and, within the Collaborative Working Agreement, will contribute to the WSSAB's priorities for 2023-24; and

iii. agreed that learning and improvement, which interfaces with Adult Safeguarding, be shared.

9. Development of the West Sussex Health and Wellbeing Board

9.1 A report was received, from the Director of Public Health, regarding the development of the West Sussex Health and Wellbeing Board, including its' key role within the Sussex Integrated Care System (ICS), and the opportunities this presented to further strengthen partnership working with key systems leaders across the local health and care system. It also outlined the proposed approach to development of the Joint Local Health and Wellbeing Strategy to be published in 2024. In receiving this report the following key points were made;

- It was noted that the process for developing a new Joint Local Health and Wellbeing Strategy (JLHWS) for the next period (to be published in 2024) needed to begin. It was recognised as important that this refresh of the strategy reflect the emergence of the ICS.

- In recognition of the implications for local government and Health and Wellbeing Board involvement in Integrated Care Systems the Local Government Association (LGA) had revised its support offer to refocus the purpose of the HWB to be able to operate effectively in the new context. This free tailored and flexible support to HWBs, could be delivered as a workshop or peer challenge activity, either as a series of workshops or a one-off session, for a group of HWBs or a single HWB.
- It was agreed that the LGA offer should be accepted with workshop style sessions as a single HWB. Board members agreed preparation was required prior to the LGA support sessions to ensure clarity on the West Sussex HWB role in the system, its collaborative approach and strategic links, its vision and timeline to avoid bringing confusion into a facilitated process.
- Board Members acknowledged that alignment across health and care partnerships would be an invaluable benefit to strengthen service delivery and assist with the strategic development for the JLHWS refresh.
- Comment was made that ICS representation from the district and borough councils had not been invited and so the Sussex ICS was being lobbied for an adjustment on this position. Board members were informed that the District Councils' Network sponsored a study by The King's Fund on why partnering with district councils is essential to achieve better health outcomes. It was recognised that as district councils deliver services that affect people's health such as housing, planning, economic development, welfare, leisure and environmental health, this made district councils key partners in integrated care systems at place level. HWB members welcomed local conversations with district and boroughs as well as the voluntary sector recognising the importance of these place based partners.
- The Director of Public Health was requested to produce a timeline on what work needed to be achieved for the JLHWS refresh and HWB review to focus the approach.

9.2 In turning to the report's recommendations the Chairman, with agreement from those present, made slight amendment to reflect discussion.

9.3 The Health and Wellbeing Board resolved that;

i. the key role that the West Sussex Health and Wellbeing Board has within the Sussex Health and Care Integrated Care System (ICS) and the significant impact this can have on improving the health and wellbeing of the local population and reducing inequalities be recognised;

ii. the Local Government Association's (LGAs) support offer to Health and Wellbeing Boards to refocus the purpose of the Health and Wellbeing Board (HWB), operate effectively in the new context, and strengthen its role in the new system architecture, be accepted with time lined preparatory work undertaken by the HWB before its first LGA support session;

iii. the need to begin to develop a new Joint Local Health and Wellbeing Strategy (JLHWS) for the next period (to be published in 2024) be noted and a timeline developed and presented to HWB members for clear direction of this process; and

iv. the recommended approach and timescales to developing the new strategy outlined in this report be approved.

10. Better Care Fund Monitoring Quarter 4 2022/23

10.1 The Board received the West Sussex 2023-25 Better Care Fund (BCF) Plan, for approval, and regular update on performance against the Better Care Fund national metrics, for Quarter 4 2022/23.

10.2 The report outlined that the Better Care Fund (BCF) is one of the government's national vehicles for driving health and social care integration. It requires integrated care boards (ICBs) and local government to agree a joint plan, owned by the Health and Wellbeing board (HWB). These are joint plans for using pooled budgets to support integration, governed by an agreement under section 75 of the NHS Act (2006).

10.3 It was noted that the schemes listed in the plan covered a broad range of areas with a focus on enabling people to stay well, safe and independent at home for longer and providing people with the right care, at the right place, at the right time. In addition, it was noted that the programme supports key priorities in the NHS Long Term Plan and the government's plan for recovering urgent and emergency care (UEC) services, and the continued delivery of more joined-up care across health and social care, aligning with key priorities for the health and care system:

- Improving overall quality of life for people, and reducing pressure on UEC, acute and social care services through investing in preventative services; and
- Tackling delayed discharge and bringing about sustained improvements in discharge outcomes and wider system flow.

10.4 It was reported that tackling the heart of health inequality experienced by communities within West Sussex, using public health data to target resources to close the gaps in health inequalities within communities was also a priority.

10.5 A review of the two year plan would be undertaken at the end of year one to allow for the consideration of any change.

10.6 In receiving this report Board members;

- gave thanks to Chris Clark as the Assistant Director (Health Integration) West Sussex County Council, Joint Strategic Director of Commissioning (West Sussex) NHS Sussex

Integrated Care Board and Paul Keogh, Better Care Fund Manager (West Sussex) and team for their work in the development of this plan and preparing the BCF reports;

- drew attention to the Local Community Networks (LCN's) noted as delivering strong collaborative, partnerships which provide opportunities to tackle health inequalities and develop effective preventative approaches responsive to local need and assets and was seen as a strong foundation for future models of care;
- welcomed this comprehensive report and highlighted the Disabled Facilities Grant (DFG) which was seen as beneficial in assisting the hospital discharge pathway. Joined up, innovative working was agreed as imperative to tackle future health issues that may arise from an increasingly elderly population and using all resources across the County, such as One Public Estate properties, assistive technologies and the DFG programme was seen key to securing the health of the population. With this in mind, it was noted that the Telecare Commissioning Strategy was being reviewed which held a synergy with the DFG.

10.7 It was resolved – that

i. the West Sussex Better Care Fund Plan for 2023-25, be approved; and

ii. the West Sussex performance against the national BCF metrics at Q4 2022/23, be noted.

11. Health & Wellbeing Board Work Programme 2023-24

11.1 In receiving the work programme 2023/24, it was requested that an item be put forward for the November meeting on winter preparedness which the chairman confirmed would receive consideration. It was also requested that the timing of the item on Housing be provided. The Director of Public Health confirmed that as this had been discussed at the last meeting of the HWB further action was required with the Strategic Housing Group before an update could be given.

11.2 Resolved – that the Health and Wellbeing Board Work Programme 2023/2024 be noted.

12. Date of next Meeting

12.1 The date of the next meeting of the Board was confirmed as 10.30am on 2 November 2023.

The meeting ended at 12.13 pm

Chairman

West Sussex Health and Wellbeing Board (HWB) Action and Recommendations tracker

The action and recommendations tracker allows the HWB to monitor responses, actions and outcomes against their recommendations or requests for further action. The tracker is updated following each meeting and circulated to Board Members electronically. Once an action/recommendation has been completed, it will be removed from the tracker.

Recommendation/ Action Topic	Meeting (date raised)	Recommendation/ Action	Responsible Officer/ Member	Follow up	Response/ Progress/ Deadlines	Status
Better Care Fund Q4 22/23	20.7.23	(1) the West Sussex Better Care Fund Plan for 2023-25, be approved; and (2) the West Sussex performance against the national BCF metrics at Q4 2022/23, be noted.	Joint Strategic Director of Commissioning	N/a	N/a	Completed
Development of the HWB	20.7.23	(1) the key role that the West Sussex Health and Wellbeing Board has within the Sussex Health and Care Integrated Care System (ICS) and the significant impact this can have on improving the health and wellbeing of the local population and reducing inequalities be recognised; (2) the Local Government Association's (LGAs) support offer to Health and Wellbeing Boards to refocus the purpose of the Health and Wellbeing Board (HWB), operate effectively in the new context, and strengthen	All HWB Members			In progress

Recommendation/ Action Topic	Meeting (date raised)	Recommendation/ Action	Responsible Officer/ Member	Follow up	Response/ Progress/ Deadlines	Status
		its role in the new system architecture, be accepted with time lined preparatory work undertaken by the HWB before its first LGA support session; (3) the need to begin to develop a new Joint Local Health and Wellbeing Strategy (JLHWS) for the next period (to be published in 2024) be noted and a timeline developed and presented to HWB members for clear direction of this process; and (4) the recommended approach and timescales to developing the new strategy outlined in this report be approved.				
West Sussex Safeguarding Adults Board Annual Report 2022-2023	20.7.23	The HWB (1) actively supports the WSSAB's strategic plan to improve prevention services and the experience of adults in West Sussex County Council who are at risk of abuse and/or neglect; (2) has provided feedback on how the Health and	Adults Social Care Assistant Director Safeguarding, Planning and Performance	N/a	N/a	Completed

Recommendation/ Action Topic	Meeting (date raised)	Recommendation/ Action	Responsible Officer/ Member	Follow up	Response/ Progress/ Deadlines	Status
		Wellbeing Board, as representative of the partner agencies and, within the Collaborative Working Agreement, will contribute to the WSSAB's priorities for 2023-24; and (3) agreed that learning and improvement, which interfaces with Adult Safeguarding, be shared.				
Public Health Update	20.7.23	In discussion, a multi-agency task force/forum was suggested to include the Voluntary, Community and Social Enterprise (VCSE) sector, connecting with communities, and a focus on climate and environmental issues of disposable vapes to young people, to deter them from vaping.	Director of Public Health			To be updated at Agenda Item 7 - Public Health Update on 2.11.2023
Minute Amendment 27.4.23	20.7.23	The West Sussex Strategic Housing Group be asked to take forward the key actions identified at the seminar, working collaboratively with stakeholders and partners across the county's health and social care system,	All			In Progress

Recommendation/ Action Topic	Meeting (date raised)	Recommendation/ Action	Responsible Officer/ Member	Follow up	Response/ Progress/ Deadlines	Status
		providing a progress update to the Health and Wellbeing Board during 2023/2024.				
Integrated Care Board Shared Delivery Plan	27.4.23	(1) the information provided in relation to the development of and engagement on the draft Shared Delivery Plan (SDP) be noted; (2) the draft SDP for year 1 and roadmap for years 2-5 be considered and feedback provided for inclusion in material to inform on the final version of the plan in June 2023; and (3) board members provide further feedback or comment by email to Chris Clark by Thursday 4th May 2023.	Chris Clark	N/a	N/a	Completed
Local Outbreak Engagement Board	27.4.23	(1) Feedback on the progress of the West Sussex Covid-19 Local Outbreak Engagement Board (LOEB) since the last quarterly report in January 2023, be provided; (2) the LOEB resolution to move to a 'standby' position and reactive if required, reflecting the progression through the living with	Alison Challenger	N/a	N/a	Completed

Recommendation/ Action Topic	Meeting (date raised)	Recommendation/ Action	Responsible Officer/ Member	Follow up	Response/ Progress/ Deadlines	Status
		Covid-19 stage of the pandemic be agreed; and (3) the value of the LOEB throughout this time maximising its collaborative strength to engage with residents and communities across West Sussex be recognised.				
West Sussex Health and Wellbeing Board Seminar - Monday, 20 February 2023	27.4.23	(1) housing and environments be continued as ongoing key priorities in the refreshed Joint Health and Wellbeing Strategy from 2024; and (2) the West Sussex Housing Group be asked to take forward the key actions identified at the seminar, working collaboratively with stakeholders and partners across the county's health and social care system, providing a progress update to the Health and Wellbeing Board during 2023/2024.	Alison Challenger	N/a	Progress update requested during 23/24 to be added to Work Programme	Completed
West Sussex Combating Drugs Partnership (CDP),	27.4.23	Recommendations Approved	Alison Challenger	N/a	N/a	Completed

Recommendation/ Action Topic	Meeting (date raised)	Recommendation/ Action	Responsible Officer/ Member	Follow up	Response/ Progress/ Deadlines	Status
Better Care Fund End of Year Return 2022/23	27.4.23	It was noted that a Chairman's Action decision would be taken on behalf of the Health and Wellbeing Board and reported to the next formal meeting of the Board.	Chris Clark	Democratic Services	By the next meeting of the Health and Wellbeing Board on 20.7.23	Chairman's Action Completed on 24.5.23 TBA at the HWB meet on 20 July 2023.
Better Care Fund	27.4.23	(1)the update on the West Sussex Better Care Fund Plan for 2022/23, be noted; (2) the Better Care Fund Planning requirements for 2023-25, be noted; and (3) the West Sussex Performance against the national Better Care Fund metrics at Quarter 3 2022/23, be noted.	Chris Clark	N/a	Resolved at meeting	Completed
Local Outbreak Engagement Board	26.1.23	Resolved that the Board has considered how the LOEB can continue to engage with residents and communities across West Sussex, maximising its collaborative strength through the 'Living with COVID-19' phase of the pandemic.	Alison Challenger	Regular updates at HWB meetings	Resolved at meeting	Completed
Cost of Living	26.1.23	Resolved – that the Health and Wellbeing Board notes the cost of living report and	All HWB Members	N/a	Resolved at meeting	Completed

Recommendation/ Action Topic	Meeting (date raised)	Recommendation/ Action	Responsible Officer/ Member	Follow up	Response/ Progress/ Deadlines	Status
		continues to identify opportunities to work collaboratively, as key systems leaders across West Sussex, to mitigate potential adverse impacts of cost of living pressures on the local population				
Children First Board	3.11.22	(1) Note the contents of this report. (2) Promote key message from Children First SEND Sub-group	Lucy Butler/Cllr Russell	N/a	Resolved at meeting	Completed
JHWS, Cost of Living	3.11.22	(1) Acknowledge the potential impacts of cost of living pressures on our local population's health and wellbeing. (2) Provide feedback on the proposed strategic approach and principles to tackle cost of living pressures in West Sussex as outlined in the Public Health Specialty Registrar's presentation. (3) Approve the Public Health Specialty Registrar to progress inclusion of the proposed cost of living addendum in the West Sussex Joint Health and Wellbeing Strategy 2019-2024 (JHWS).	Dani Plowman/Alison Challenger	N/a	Resolved at meeting	Completed

Recommendation/ Action Topic	Meeting (date raised)	Recommendation/ Action	Responsible Officer/ Member	Follow up	Response/ Progress/ Deadlines	Status
Better care Fund	3.11.22	(1)Approve the West Sussex Better Care Fund Plan for 2022/23. (2) Approve the West Sussex Capacity and Demand Plan for Intermediate Care Services Q3 & Q4 2022/23. (3) Note the West Sussex performance against the national BCF metrics at Q1 2022/23.	Chris Clark	N/a	Resolved at meeting	Completed
Cost of Living	3.11.22	Establish a Health and Wellbeing Working Group on Cost of Living	Chairman will consider item for inclusion	At agenda prep meeting 5.1.23	The establishment of a working group is not required; a comprehensive programme of work is already underway to address cost of living pressures across West Sussex. Regular updates to be provided at quarterly Health and Wellbeing Board meetings	Completed

Recommendation/ Action Topic	Meeting (date raised)	Recommendation/ Action	Responsible Officer/ Member	Follow up	Response/ Progress/ Deadlines	Status
Work Programme	3.11.22	(1)Request to add item on work programme for next meeting to update on Cost of Living (2)Request to add item on Health and Care workforce planning	Chairman will consider item for inclusion	At agenda prep meeting 5.1.23	(1) Cost of Living Item added to Work Programme (2) This item to be dealt with and included in Integrated Care System updates on the work programme.	Completed

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Report to West Sussex Health and Wellbeing Board

25 January 2024

West Sussex Safeguarding Children Partnership – annual report 2022-23

Report by, Sally Kendal, West Sussex Local Safeguarding Children Board Manager

Summary

The West Sussex Safeguarding Children Partnership's WSSCP) annual report, 2022-23 was completed in accordance with statutory guidance available at the time[1] which stipulated:

"In order to bring transparency for children, families and all practitioners about the activity undertaken, the safeguarding partners must publish a report at least once in every 12-month period. The report must set out what they have done as a result of the arrangements, including on child safeguarding practice reviews, and how effective these arrangements have been in practice."

The WSSCP is led by three statutory Lead Safeguarding Partners: WSCC Children's Services, Sussex Police and NHS Sussex (Integrated Care Board). It is their equal and joint responsibility to ensure that children are safeguarded in West Sussex by co-ordinating an effective multi-agency approach. The three Lead Partners are accountable to the Department for Education for the WSSCP's performance. The annual report is a means by which assurance is provided about where progress has been made, whilst also highlighting areas requiring development and/or improvement.

West Sussex County Council's Health and Wellbeing Board WSCC HWB) no longer has a statutory function in terms of sign off the WSSCP's annual report. Nevertheless the report is shared for scrutiny and under the terms of the Collaborative Working Agreement (CWA) enables the WSCC HWB to be sighted on the WSSCP's work. It also allows the Partnership and Board to reflect upon and align their activities to ensure focus of collective resources on priority work areas.

Recommendation(s) to the Board

The Health and Wellbeing Board is asked to;

(1) Note the contents of this report.

(2) Note the forthcoming legislative changes under revised statutory guidance – Working Together to Safeguard Children 2023 (issued by the Department for Education in December 2023). This means that the WSSCP will be required under the revised statutory guidance to report to the DfE by 30 September

[1] Working Together to Safeguard Children 2018 (Department for Education – published July 2018).

2024 on the preceding business year (April 2023-March 2024) on several new criteria such as providing "evidence of how safeguarding partners are ensuring the adequate representation and input of education at both the operational and strategic levels of the arrangements".

Relevance to Joint Health and Wellbeing Strategy

The WSSCP's priority work areas are aligned to three key Starting well' priorities:

- **'Improved mother and baby wellbeing'** – the WSSCP worked closely with WSCC Public Health and across Sussex to promote safer sleeping and baby care (ICON) messages. The WSSCP reinvested in the DadPad 'app' complemented by co-ParentPad to provide resources to support new parents living in West Sussex for a further four calendar years (2023-26).

- **'Children growing in a safe & healthy home environment with supporting and nurturing parents and carers'** – a refresh of the WSSCP's neglect strategy commenced, the work driven through the Improvement and Assurance Group during 2023-24 and includes e.g. an ongoing neglect champions forum and toolkits to support practitioners to identify and monitor neglect. It also supported roll out of WSCC's relationship based working with families training to help embed the Family Safeguarding Model.

- **'Good mental health for all children'** – significant learning focussed on suicide prevention was commissioned by the WSSCP's Case Review Group (CRG) during this year with the ambition to take forward learning to improve outcomes for children and support families in these circumstances. The WSSCP delivered its annual conference about online safety in collaboration with the WSCC Community Safety Partnership. The key note speaker from Grassroots Suicide Prevention charity, explored the impacts of on line abuse and exploitation on children's emotional health and wellbeing.

- **'Children and young people leaving care are healthy and independent'** In addition to learning around suicide prevention the WSSCP also identified learning around transitions work in the context of concerns around exploitation and substance misuse. As a result the WSSCP commissioned training for multi-agency professionals around suicide prevention 'adultification' of children approaching adulthood and exploitation.

1 Background and context

The WSSCP's annual report is retrospective and covers the period April 2022 to March 2023.

The WSSCP is an independent body, its business support functions are currently hosted by the local authority. Statutory partnerships are required to work together as joint and equal partners to shape bespoke arrangements which respond to local need.

The West Sussex Collaborative Working Agreement (CWA) provides a means to effect strategic join up/alignment across four Boards/Partnerships: Health and Wellbeing Board, Safeguarding Adults Board, Safer West Sussex Partnership and the WSSCP. Strategic Leads met twice during the year to focus on joining up across four common areas:

- Emotional health and Wellbeing of Children: Mental Health
- Exploitation
- Transitions to Adulthood
- Shared learning

2 Proposal details

2.1 The WSSCP continued to focus on Neglect, Exploitation and improving multi-agency working priority themes as part of its business plan delivery. This report provides a detailed overview of individual partner agencies and organisations contributions to these priority areas including raising awareness, embedding learning and improving practice.

2.2 Key achievements include:

- Developing a multi-agency approach for children who are deemed to be at high risk of self-harm or suicide, including a 'triage' approach. It provides management support and oversight of emerging risks involving specific children - allowing for early review and safety plans to be put into place. Schools can refer children of concern directly into this team for a rapid, multi-agency response. This innovative work led to a nomination at the HSJ patient safety awards in September 2022 and subsequently winning the 'Mental Health Initiative of the Year' award. The judges described the new process as 'innovative, partnership working at its best, and ultimately saving lives'. This approach has been shared with partner agencies in the region and beyond.

- ICON and DadPad: roll out of Dad Pad, which also included ICON messaging continues to be successful, with at least 50% of new fathers accessing the DadPad app in West Sussex. West Sussex will also benefit in 2023-24 from the introduction of the new 'Co-ParentPad' resource. There is a continued focus on key safer sleeping and abusive head trauma messages to ensure they are embedded across the entire Partnership, (i.e. not just midwifery and health visiting).

- Learning and Development (L&D) activity included a revised training offer centred on learning from audit and reviews, e.g. suicide prevention, child exploitation, trauma informed practice and adultification. Another L&D highlight saw the WSSCP host a face-to-face Conference about Online Safety.

- Pan Sussex work included a Pan-Sussex Neglect and Poverty Task and Finish Group, chaired by the East Sussex Principal Social Worker; the group completed a review of the neglect matrix used across East Sussex. The Pan-Sussex group considered best practice and learning across all

three areas and the application of shared language and tools to complement existing processes.

2.3 The Partnership continued to address challenges and areas for development to ensure effective partnership working, including:

- An increased referral rate and demand for services with rising numbers of children on waiting lists with unmet mental health needs. There is a national shortage of Tier 4[2] provision and also appropriate social care placements.
- Evidencing impact of the Partnership's learning and improvement work on outcomes for children continues to be a key challenge. The Partnership has commissioned an independent reviewer to facilitate an impact of learning event for practitioners and managers in 2023-24 to help the WSSCP to understand whether it has successfully embedded learning from reviews into practice. The Partnership needs to identify and utilise the most effective ways to extract, disseminate and embed learning to make a measurable difference to children and families.
- Capacity to deliver – a large case review workload placed pressures on (finite) partner agency/organisation resources and the WSSCP business support team, meaning that there was reduced activity across other delivery areas.
- The need for improved join up of working with schools as well as the voluntary and community sector.

3 Consultation, engagement and advice

3.1 The annual report was produced using data and narrative text provided by agencies and organisations including the local authority, Districts and Boroughs, Sussex Police, NHS Sussex and local 'health' service providers.

3.2 Governance – the WSSCP subgroup – Improvement and Assurance Group led on delivery of the annual report, which received final sign off by statutory Lead Partners at the WSSCP Steering Group in September 2023.

Contact: Sally Kendal, Strategic Partnership Manager, West Sussex Safeguarding Children Partnership. Tel: 0330 222 5241

Appendices Presentation Papers

Link to the West Sussex Safeguarding Children Partnership's (WSSCP) annual report, published on the WSSCP's website.

Background papers

- Link to DadPad/Co-ParentPad
- Link to ICON

  Link to Multi-Agency Mental Health Education Triage (MAMHET) guidance

[2] Provision of Child and Adolescent Mental Health (CAMHS) Tier 4 inpatient services.

Report to West Sussex Health and Wellbeing Board

25 January 2024

West Sussex Suicide Prevention Framework and Action Plan 2023-2027, and Sussex Suicide Prevention Strategy and Action Plan 2024-2027

Report by: Alison Challenger, Director of Public Health

Summary

Following the progress update presented to the Health and Wellbeing Board on 27 April 2023, this report presents the final West Sussex Suicide Prevention Framework and Action Plan 2023 – 2027 (including Year 1 action plan to April 2024), and the Sussex Suicide Prevention Strategy and Action Plan 2024 - 2027. Both focus on all ages and follow national guidance and strategy. They have been developed collaboratively as partnership documents, with partners spanning the NHS, Local Government, Voluntary, Community and Social Enterprise (VCSE) organisations, and blue-light services, enabling a whole systems approach to suicide prevention for our local population and across the Sussex geography (Brighton and Hove, East Sussex, West Sussex).

Recommendation(s) to the Board

The Health and Wellbeing Board is asked to;

(1) Approve the West Sussex Suicide Prevention Framework and Action Plan 2023 – 2027.

(2) Note the Sussex Suicide Prevention Strategy and Action Plan 2024 – 2027 and its alignment with the West Sussex Suicide Prevention Framework and Action Plan 2023-2027.

(3) Recognise the significant impact that implementation and delivery of both the framework, strategy and their action plans can have on reducing the risk of suicide in West Sussex and Sussex-wide.

(4) To consider how the West Sussex Health and Wellbeing Board, as key systems leaders, can support this approach to reducing the risk of suicide across our local population, to maximise our collaboration and impact.

Relevance to Joint Health and Wellbeing Strategy

The West Sussex Suicide Prevention Framework and Action Plan 2023-2027 and the Sussex Suicide Prevention Strategy and Action Plan 2024-2027 support the West Sussex Joint Health and Wellbeing Strategy (JHWS) 2019-2024's focus on improving the health and wellbeing of our residents, reducing gaps in health and wellbeing between communities, and ensuring joined up working and services.

The West Sussex JHWS refers to the Suicide Prevention Strategy as a key strategy (within the Living and Working Well theme) that links with the JHWS. In addition, both the framework, strategy and their action plans, aim to maximise opportunities for prevention across the life course, aligning with the JHWS's lifecourse approach to improving health and wellbeing.

1 Background and context

1.1 Suicide is a serious public health problem; however, suicides can be prevented with timely, evidence-based interventions. For an effective response, local, comprehensive multisectoral suicide prevention strategies are needed[1].

1.2 Every death by suicide has a devastating impact on families, friends and communities. The factors leading to someone taking their own life are complex and are often linked to circumstances and experiences over an extended period. Risk is often higher in those who are more disadvantaged or socially excluded[2].

1.3 The rate of suicide in West Sussex of 11.5 per 100,000 people (approximately 75 people per year) exceeds the England average of 10.4 but is lower than other parts of Sussex (Brighton and Hove rate is 14.1 and East Sussex rate is 12.1 per 100,000 people)[3].

1.4 The need to develop local plans that engage a wide network of stakeholders was established in the government's national strategy for England, 'Preventing suicide in England' released in 2012. Councils were given the responsibility for leading the development of local suicide action plans through their work with health and wellbeing boards. The new national Suicide Prevention Strategy for England 2023 to 2028 (September 2023),[2] emphasises the role of the wider system, including the Integrated Care System (ICS) in co-ordinating action to prevent suicides.

1.5 Historically, the previous West Sussex Suicide Prevention Strategy 2017-2020 was shared with the West Sussex Health and Wellbeing Board. East Sussex and Brighton and Hove have also developed local plans to accompany the new Sussex wide strategy, and have shared these with respective Health and Wellbeing Boards during November and December 2023.

2 Working collaboratively across Sussex on suicide prevention

2.1 For many years, partner organisations across Sussex have been working together closely on suicide prevention. This collaboration has significant benefits including shared learning, innovation and efficiencies, for example in delivering Sussex level communication campaigns. Some key partners, such as Sussex Police and Sussex Partnership NHS Foundation Trust, operate across the whole footprint which enhances Sussex collaboration.

2.2 Between 2019 and 2023, Sussex benefited from an NHS England (NHSE) funded suicide prevention and self-harm prevention programme as part of the national Transformation funding programme. It was delivered across the Sussex geography of West Sussex, East Sussex and Brighton and Hove.

[1] One in 100 deaths is by suicide (who.int)
[2] How does living in a more deprived area influence rates of suicide (ONS.GOV.UK)
[3] Local Authority Health Profiles - Data - Office for Health Improvements and Disparities OHID (fingertips.phe.org.uk)

Sussex Suicide Prevention Strategy and Action Plan 2024-2027

2.3 As the NHSE funded suicide prevention and self-harm prevention programme came to an end, the need to refresh the strategic approach across Sussex became apparent and a Sussex-wide Suicide Prevention Strategy and Action Plan was developed by the Sussex Suicide Prevention Steering Group. Membership of this group includes NHS Sussex, Sussex Partnership NHS Foundation Trust, Sussex Police, Voluntary Community and Social Enterprise (VCSE) sector representatives and the three upper tier local authorities (Brighton and Hove, East Sussex, West Sussex).

2.4 The Sussex Suicide Prevention Strategy and Action Plan 2024-2027 was approved by the Sussex Mental Health Learning Disability and Autism Board in September 2023. Following publication of the national Suicide Prevention Strategy for England 2023 to 2028[4] later that same month (11 September), the Sussex Strategy was given minor updates to reflect the latest national guidance (see Appendix 1).

3. West Sussex Suicide Prevention Framework and Action Plan 2023 – 2027

3.1 Work commenced in September 2022 to develop the West Sussex Suicide Prevention Framework and Action Plan 2023-2027 (see Appendix 2), which updates the West Sussex Suicide Prevention Strategy 2017-2020. This framework and action plan was developed by the West Sussex Suicide Prevention Steering Group; a multi-agency group with representatives from West Sussex County Council, NHS Sussex, Sussex Partnership NHS Foundation Trust, the Voluntary, Community and Social Enterprise (VCSE) sector, Sussex Police, and wider partners. It's formal reporting line is to the Sussex Suicide Prevention Group; it also provides updates to the West Sussex Mental Health Oversight Board, Children's First Board, West Sussex Safeguarding Children's Partnership, NHS Sussex Children's Board as well as West Sussex Health and Wellbeing Board. Additionally, a suicide prevention partnership group reports to the West Sussex Suicide Prevention Steering Group that includes wider membership of organisations supporting suicide prevention and a sub-group focused on suicide prevention for children and young people.

3.2 The purpose of the document is to provide a framework and plan for action for multi-agency partners in West Sussex to work together to reduce the risk of suicides. It covers all ages, and dovetails with the Sussex Suicide Prevention Strategy and Action Plan 2024-2027, to ensure an aligned approach locally and Sussex-wide. Both documents were developed in line with the guidance of the previous national suicide prevention strategy for England (2012), and as with the Sussex strategy, the West Sussex framework and action plan was updated following the publication of the Government's updated national strategy, adapting and absorbing the latest evidence and information provided.

3.3 Two main areas of focus have informed the development of both the West Sussex and Sussex documents:

- A review of the latest evidence, including academic research, government policy, public health guidance, and national and local data.

[4] Suicide prevention in England: 5-year cross-sector strategy - GOV.UK (www.gov.uk)

- An engagement exercise with key stakeholders from the Sussex Suicide Prevention Partnership in summer 2022, where views were sought on the proposed action areas for the Sussex Suicide Prevention Strategy. Groups and individuals consulted include community and voluntary sector groups, NHS, and local authorities.

3.4 The final version (including updates) of the West Sussex Suicide Prevention Framework and Action Plan 2023-2027 has been presented to and discussed with the following strategic and partnership groups: West Sussex Mental Health Oversight Board, Adults Services Directorate Leadership Team, Children, Young People, and Learning Directorate Leadership Team, Safer West Sussex Partnership, West Sussex Combating Drugs Partnership, West Sussex Domestic Violence and Abuse Steering Group, West Sussex Suicide Prevention Steering Group, West Sussex County Council Executive Leadership Team (ELT) and shared with the West Sussex Health and Care Partnership Executive, and West Sussex Safeguarding Children's Partnership Board.

3.5 In line with the national and Sussex suicide prevention strategies the framework (Appendix 2) aims to reduce the risk of suicide, improve support for people who self-harm and improve support for those bereaved by suicide. It has nine key action areas that are mapped against the national strategy.

4. Proposal details

4.1 The purpose of this report is to provide an update to the Health and Wellbeing Board on the actions being taken to reduce the risk of death by suicide across West Sussex and the wider geography of Sussex.

4.2 Approval is sought from the Board for the West Sussex Suicide Prevention Framework and Action Plan 2023-2027, and their views on how, as key systems leaders, they can support the approach to reducing the risk of suicide across our local population, to maximise our collaboration and impact.

5. Consultation, engagement and advice

5.1 The West Sussex Suicide Prevention Framework and Action Plan 2023-2027 was developed by the West Sussex Suicide Prevention Steering Group, a multi-agency group. The process of developing the plan involved an engagement exercise with key stakeholders from the Sussex Suicide Prevention Partnership in summer 2022, where views were sought on the proposed action areas. Groups and individuals consulted includes Community, Voluntary and Social Enterprise (VCSE) sector groups, the NHS, and local authorities.

5.2 Updates and drafts of the both the Sussex Suicide Prevention Strategy and Action Plan 2024-2027 and the West Sussex Suicide Prevention Framework and Action Plan 2023-2027, have been shared with key partnership boards.

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Appendices

Appendix 1: Sussex Suicide Prevention Strategy and Action Plan 2024-2027
Appendix 2: West Sussex Suicide Prevention Framework and Action Plan 2023-2027

Background papers

Suicide prevention strategy: action plan - GOV.UK (www.gov.uk) (opens in a pdf)

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Sussex Suicide Prevention Strategy and Action Plan

2024 -2027

Dr Mike McHugh: Consultant in Public Health (Interim), Sussex

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1.0 Introduction

1.1 Background

Suicide is used in this strategy to mean a deliberate act that intentionally ends one's life. The World Health Organisation highlights suicide as a major public health risk, accounting for one in 100 of all deaths globally[1]. They estimate that for every suicide there are 20 non-fatal suicide attempts[2].

Every death by suicide is an individual tragedy and a cause of huge distress to friends, families, and communities. It is estimated that the cost to the economy of each suicide is £1.67 million[3]. For every one suicide there can be up to 135 people significantly impacted[4]. For any one year, approximately 24,000 people in Sussex were affected by suicide. We know that across Sussex, the number of people who have enduring and in many cases a life-long negative impact from suicide is substantial.

There is rarely a single reason why someone takes their own life. Suicide is often the end point of a complicated history of risk factors and distressing events. It is best understood through life circumstances, in a complex interplay of risk factors and adverse experiences. Suicide risk also reflects wider inequalities as there are marked differences in suicide rates according to people's social and economic circumstances, with those in poorer communities and those who are socially excluded more likely to be affected.

Suicides are not inevitable. There are many ways in which individuals, communities, services, and society can help to prevent suicides. An inclusive society that builds individual and community resilience, avoids the marginalisation of individuals, and supports people at times of personal crisis will help to prevent suicides.

As a significant percentage of people who die by suicide are not in contact with secondary mental health or social care services, action is also required beyond the health and social care system. Many have not told anyone that they're feeling suicidal or made a suicide attempt in the past, although it is known that many men will have visited their GP for other reasons in the 3 months prior to their death.[5] Real partnership is required with community groups, local business and the third sector to help identify and support people at risk of suicide and those bereaved by suicide.

Preventing suicide is therefore achievable. The delivery of a comprehensive local partnership suicide prevention strategy is essential to reduce deaths by suicide by suggesting interventions that build community resilience and target groups of people at heightened risk. This Strategy and Action Plan have been developed using the combined knowledge, expertise and resources of organisations and individuals across the public, private and voluntary sectors in Sussex.

On 11th September 2023 the government published its new national strategy "Suicide Prevention in England: 5-year cross-sector strategy.[6] This strategy is the update to the

previous strategy published in 2012 and there have been five government progress reports published since then, with the most recent report issued in March 2021. The new national strategy reflects the latest evidence and national priorities for preventing suicides, outlines 8 action areas and covers the following priority groups and risk factors at population level.

Priority groups	**Risk factors at a population level**
• Children and young people • Middle-aged men • People who have self-harmed • People in contact with mental health services • People in contact with the justice system • Autistic people • Pregnant women and new mothers	• Physical illness • Financial difficulty and economic adversity • Gambling • Alcohol and drug misuse • Social isolation and loneliness • Domestic abuse

Throughout the life of this strategy, we will we continue to measure and monitor progress against implementation and set out ambitious actions that will tackle these challenges as they arise, focussing on the interventions and actions that will make the biggest difference.

1.2 Vision and Aims

In line with the national strategy*, Suicide prevention in England: 5-year cross-sector strategy*[7], and associated *Suicide prevention strategy: action plan*[8] the aims of the Sussex Suicide prevention Strategy and Action Plan are to:

- reduce the suicide rate over the next 5 years – with initial reductions observed within half this time or sooner.
- improve support for people who have self-harmed.
- improve support for people bereaved by suicide.

It is our vision that Sussex is a place where:

- we are committed to reducing the risk factors and increasing the protective factors for suicide across the life course.
- we build individual and community resilience to improve lives and prevent people falling into crisis by tackling the risk factors for suicide.
- we recognise that suicides can be prevented, and that people do not inevitably end up considering suicide as a solution to the difficulties they face.

- we create an environment where anyone who needs help knows where to get it and is empowered to access that help.

In line with the national strategy this is a multi-agency partnership strategy whereby suicide is everybody's business and there is joint responsibility and joined up accountability for delivery of action at local levels.

At a place-based level all three areas in Sussex have suicide prevention action plans delivered via multi-agency partnerships. Each organisation may also have their own strategies and plans in place, this includes Sussex Partnership NHS Foundation Trust, the local mental health trust.

The pan-Sussex Suicide Prevention Strategy builds on local plans and capitalises on the added value and economies of scale inherent in a pan-Sussex approach. It serves as a framework for action at both Sussex level and for local approaches at place level- highlighting actions best delivered at system wide level, whilst recognising that implementation will be assisted by the existing local stakeholder strategies and groups.

The Sussex Suicide Prevention Strategy has been developed by the pan-Sussex Suicide Prevention Steering group with support from place-based suicide prevention groups. Members include Brighton and Hove, East and West Sussex Public health, Sussex Integrated Care Board, Sussex Partnership Foundation Trust, Sussex Police and representatives for the Community and Voluntary sector.

The progress of the strategy will be monitored through this group based on the *Sussex Suicide Prevention Strategy One Year Action Plan*, updated annually. See section 8.3.

In 2022, prior to the publication of the latest national strategy, an engagement exercise took place with key stakeholders from the Sussex Suicide Prevention partnership, giving partners the opportunity to shape the 'Statements of Intent' for national Action Areas. The approach of this strategy is based on the action areas of the 2023 national strategy. These are set out below.

Eight key action areas in Sussex Suicide Prevention Strategy and Action Plan (2024-27):

Action Area 1: Improving data and evidence to ensure that effective, evidence-informed and timely interventions continue to be developed and adapted.

Support learning, research, data collection and monitoring.

It is critically important to improve system learning from available data and to adapt/escalate approaches where possible, taking account of intersectionality of factors that contribute to suicide.

Action area 2: Provide tailored, targeted support to priority groups, including those at higher risk.

Several population groups face an increased risk of suicide. Our first priority is to reduce risk in these groups. We will ensure there is bespoke action and interventions that are effective and accessible for everyone.

Action area 3: Addressing common risk factors linked to suicide at a population level to provide early intervention and tailored support.

Tailor approaches to improve mental health in specific groups.

Work done 'upstream' to promote good mental health, emotional resilience and wellbeing can play a role (by reducing the flow of people into 'at risk' groups) in our plans for suicide prevention. This includes giving people the tools and confidence to talk openly about their mental health.

Action area 4: Promoting online safety and responsible media content to reduce harms, improve support and signposting, and provide helpful messages about suicide and self-harm.

There has been emerging evidence of the link between the online environment and suicide across different age groups. Internet use for suicide-related purposes has been linked to children and young people who have presented to hospital for self-harm or a suicide attempt and middle-aged men who have died by suicide.

Action area 5: Providing effective crisis support across sectors for those who reach crisis point.

It is essential that timely and effective crisis support is available to those who need it.

Research by NCISH suggests that, of all deaths by suicide by people in contact with mental health services in England between 2010 and 2020, 15% were under the care of crisis resolution and home treatment teams[9] (CRHTTs). This is equivalent to 180 suicides per year on average. NHS 24/7 mental health crisis lines currently receive around 200,000 calls each month. And many more people are in contact with crisis services provided by other organisations, including those from the voluntary sector.

Action area 6: Reducing access to means and methods of suicide where this is appropriate and necessary as an intervention to prevent suicides.

Suicides often take place during a period of crisis. Reducing access or delaying access to the means of suicide for that crisis moment can prevent a suicide from taking place.

Action area 7: Providing effective bereavement support to those affected by suicide.

People who are bereaved through suicide are at greater risk of suicide and poor mental health.

Action area 8: Making suicide everybody's business so that we can maximise our collective impact and support to prevent suicides.

System leadership, quality improvement and communications requires clear leadership and governance across the wider suicide prevention system are essential to coordinate and drive suicide prevention efforts. Effective, sensitive cross partner and wider communication also sits at the heart of impactful suicide prevention approaches.

Several other national frameworks, evidence, and resources were also used to shape the Sussex Suicide Prevention Strategy and Action Plan (2024-2027). See **Appendix 1.**

2.0 Moving to Action in Sussex

The Sussex Suicide Prevention Strategy and Action Plan (2024-2027) supports taking early action across a range of settings to prevent individuals from reaching the point of personal crisis where they feel suicidal, whilst also ensuring that those in crisis will get the support they need.

The Sussex Suicide Prevention Steering Group, a multi-agency partnership group, will oversee the delivery of this strategy and action plan. Members of the partnership include: Brighton and Hove, East and West Sussex Public health, Sussex Integrated Care Board, Police, Sussex Partnership Foundation Trust and representatives for the Community and Voluntary sector.

The multi-agency Sussex Suicide Prevention Steering Group share the following values:

2.1 Values

- Across Sussex we don't tolerate health and social inequalities or stigma. We want to dismantle prejudicial attitudes and discriminating behaviour directed towards suicide and at people with lived experience of mental illness, suicide, and self-harm.
- We use a people-first and trauma-informed approach which acknowledges the challenges that individuals face. We involve people with lived experience to inform our approach to suicide prevention and suicide bereavement.
- Collaborative working with partners - we use a whole-system approach, working in collaboration with partners and stakeholders to address the complex nature of suicide and self-harm. Suicide is everyone's business.
- Data driven, evidence based-we are guided by local data and real-time surveillance which enables us to quickly and effectively help those who are most at risk. We are committed to improving data collection with a focus on recently identified risk factors and high-risk groups.
- System leadership (we act as system leaders to drive change throughout Sussex).
- We look after our front-line staff, and support an inclusive, 'no-blame' culture.

2.2 The Case for Working at a Pan-Sussex Level

Between 2019 and 2023, Sussex benefited from an NHS England funded suicide prevention and self-harm programme which was delivered across Sussex. This initiative capitalised on cross partner collaboration and integration of programmes of work involving many local organisations, both statutory and voluntary. The work highlighted the benefits of working at scale, bringing efficiencies and innovations across Sussex whilst also enhancing placed based approaches. (See **Appendix 2** for evidence of achievements of NHSE Sussex programme)

Now the NHS England funded programme has come to an end, the need for a more cohesive and formalised response to emerging trends across Sussex has become apparent.

Working at a Pan-Sussex level will bring many advantages. This does not negate the need for local place-based plans and activities but brings added value to the work already taking place. The Sussex Suicide Prevention Strategy and Action Plan can serve as a framework for both pan-Sussex and local approaches.

2.3 Areas Best Approached at Pan-Sussex Level

The following areas lend themselves to strong collaboration at Sussex level:

Suicide Response:

This includes collation of timely suicide data, including Real Time Surveillance, leading to ascertainment of ongoing suicide risk and the need for bereavement support (including support for front-line staff).

Response will also incorporate engagement with organisations outside Sussex when people who die as a result of suicide in Sussex are not Sussex residents.

Working with Sussex-wide partners:

Collaborative working with key partners that operate under a Sussex wide footprint: Sussex Police, Sussex Partnership NHS Foundation Trust, Sussex Integrated Care Board, Acute Medical Trusts, educational settings, voluntary and community sector etc.

Suicide Prevention and awareness training:

Where possible training will be developed and co-ordinated at Sussex level.

Online Harms, Communications and Responsible Media Reporting:

Communications relating to suicide and suicide prevention will be co-ordinated and harnessed across the wider Sussex partnership, bringing communications teams from partner organisations together for a collective approach. This will include wider mental health communications strategies e.g., to tackle mental illness stigma.

Specific action will be taken to reduce online harms and the media will be encouraged to consistently portray suicide and self-harm content responsibly, following high-quality guidelines and resources to do this.

Lived experience:

Approaches to tackling causes of suicide will be informed by input from those with lived experience across Sussex (includes people who are bereaved by suicide, people who have felt suicidal, people who have attempted suicide, and their families and carers)

Self-harm:

Addressing the causes and impact of self-harm lends itself to a Sussex wide approach by building on recent work by the self-harm learning network and addressing the recommendations of the Foundations for our future Strategy (children and young people's mental health).

Co-existing illness:

Tackling mental illness and substance abuse will be more effective at pan-Sussex level given that there is a single main secondary mental health service provider across Sussex (SPFT) and a single organisation (CGL) that provides substance misuse treatment services for each of the three places across Sussex.

Expanding focus on existing, new, and emerging priority groups

Newly emerging priority groups e.g., Children and young people, looked after children and care leavers, pregnant women and new mothers, LGBTQ+, neurodivergent individuals, ethnic minorities including those who are Gypsy, Roma or Travellers, refugees and asylum seekers, people with harmful gambling behaviours, victims and witnesses of domestic abuse, people who misuse substances, people in contact with criminal justice system, younger Armed Force Veterans may be best tackled at Sussex level.

2.4 Governance (Oversight)

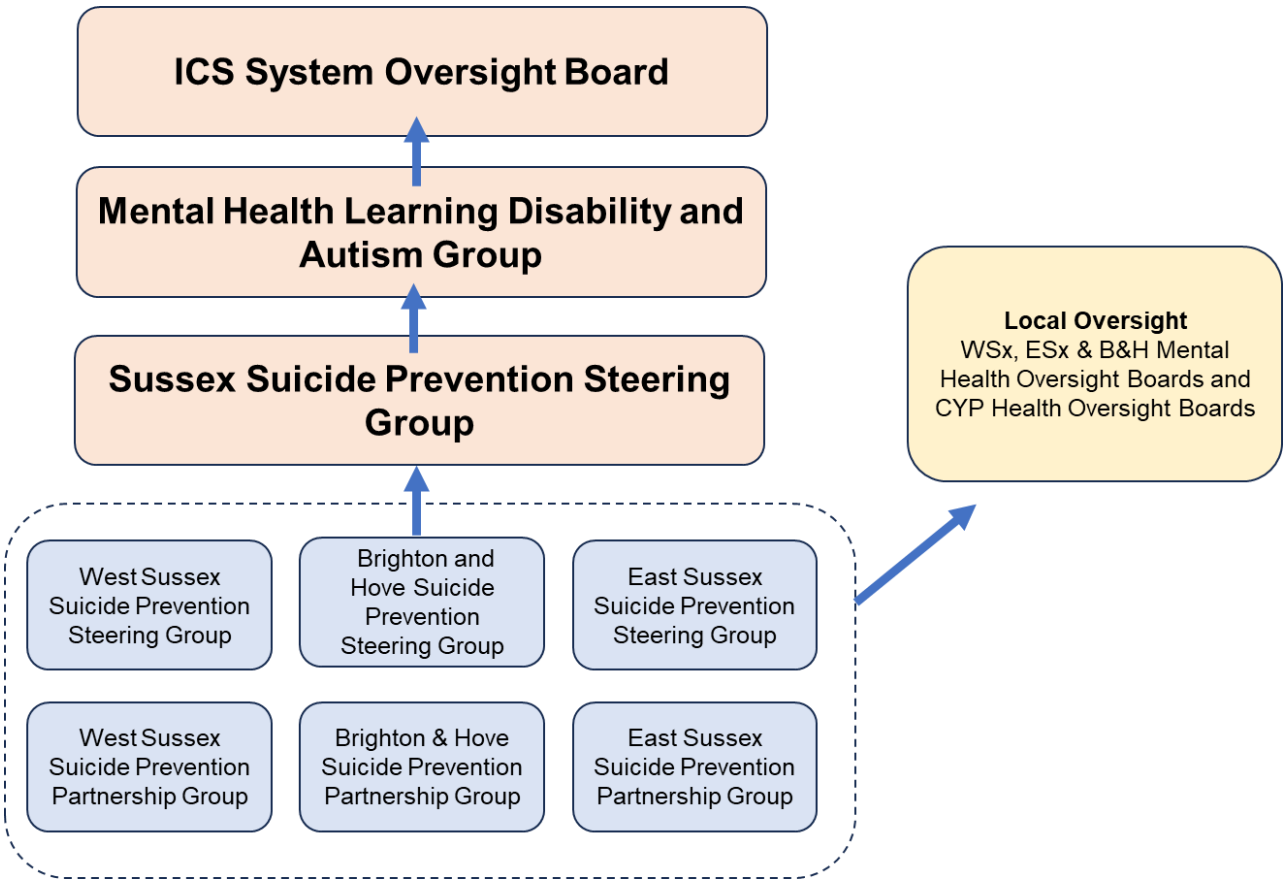
The need to develop local plans that engage a wide network of stakeholders was established in the government's national strategy for England, '*Preventing suicide in*

England[10]' released in 2012. Councils were given the responsibility for leading the development of local suicide action plans through their work with health and wellbeing boards.

The new national strategy highlights the importance of cross-sector working and joint action, including at a local level through integrated care partnerships, integrated care boards (ICBs), local authorities and local suicide prevention organisations.

The Sussex Suicide Prevention Strategy (2024-2027) will be governed by the Sussex Suicide Prevention Steering Group. This group will provide feedback directly to local Directors of Public Health, to local oversight boards and to the Mental Health Learning Disability and Autism Board of the ICS.

Governance of the Sussex Suicide Prevention Strategy



The Sussex Suicide Prevention Steering Group will work to ensure that prevention is co-ordinated well both at a Sussex level and with the three places of Brighton and Hove, West Sussex and East Sussex. It will further work to ensure it aligns with and complements other plans and strategies, including,

1. The Sussex Partnership NHS Foundation Trust (SPFT) 'Towards Zero Suicide' plan based on NCISH's 'Ten ways to improve safety'.

2. Sussex Foundations for Our Future (FFOF) Children and Young People's Mental Health Strategy.

2.5 Working Together

Whilst public health teams in local authorities provide leadership, multi-agency partnerships have responsibility for overseeing and delivering much of the suicide prevention activity, addressing as they do many of the known risk factors, such as alcohol and drug misuse[11].

Councils (including district, borough, and parish councils) span efforts to address wider determinants of health such as employment and housing. NHS Integrated Care Boards hold the responsibility for all health and care services and specific to suicide prevention, bereavement support. In addition, there are important opportunities to reach local people who are not in contact with health services through online initiatives and through working with the voluntary and community sector.

NHS trusts provide over half of all NHS hospital, mental health and ambulance services. Consequently, they have a crucial role to play in suicide prevention including front line mental health services. Wider services can be at the heart of delivering our ambition of 'every interaction matter's including :

- first appointments with midwives and ongoing antenatal care
- referrals to GPs and/or specialist mental health services
- engagement with health visitors
- engagement of a specialist teenage pregnancy or drug and alcohol specialist midwife

3.0 Context of Suicide Prevention

3.1 Policy Context

On 11th September 2023, the Department of Health and Social Care published a new national strategy*, Suicide prevention in England: 5-year cross-sector strategy*[12], and associated *Suicide prevention strategy: action plan*[13].

This new strategy sets out the national ambitions for suicide prevention over the next 5 years and the steps we need to take collectively to achieve them. This includes individuals, organisations across national and local government, the NHS, the private sector, the VCSE sectors, and academia.

To be successful, we should all consider and incorporate the following principles in the design and delivery of interventions, services, resources and activities to prevent suicides. These are:

- suicide is everybody's business. Everyone should feel they have the confidence and skills to play their part in preventing suicides – not just those who work in mental health and/or suicide prevention directly – and take action to prevent suicides within and outside of health settings.
- mental health is as important as physical health. We must reduce stigma surrounding suicide and mental health, so people feel able to seek help – including through the routes that work best for them. This includes raising awareness that no suicide is inevitable.
- nobody should be left out of suicide prevention efforts. This includes being responsive to the needs of marginalised communities, addressing inequalities in access to effective interventions to prevent suicides. It also requires listening to individuals and being responsive to their needs.
- early intervention is vital. In addition to providing support to those experiencing crisis and/or suicidal thoughts or feelings, action needs to be taken to stop people reaching this point.
- voices, perspectives and insights of people with personal experience should inform the planning, design and decisions at all levels of suicide prevention activity. This includes people with experience of feeling suicidal, those who have made previous suicide attempts, and people who are bereaved by suicide.
- strong collaboration, with clarity of roles, is essential. Suicide prevention is the responsibility of multiple government departments, as well as wider public, private and VCSE sector organisations.
- timely, high-quality evidence is fundamental. Practice and policy should be informed by high-quality data and research, and be responsive to trends and emerging evidence. This includes harnessing digital technology and data advancements to provide earlier interventions and wider access to support.

This will require a national government effort, as well as continued action across the NHS, local government, the voluntary, community and social enterprise (VCSE) sectors, employers and individuals. The aim of this cross-government strategy is to bring everybody together around common priorities and set out actions that can be taken to:

- reduce the suicide rate over the next 5 years – with initial reductions observed within half this time or sooner.
- improve support for people who have self-harmed.
- improve support for people bereaved by suicide.

Over the next 5 years, national priorities for action include:

- Improving data and evidence to ensure that effective, evidence-informed and timely interventions continue to be developed and adapted.

- Tailored, targeted support to priority groups, including those at higher risk, to ensure there is bespoke action and that interventions are effective and accessible for everyone.
- Addressing common risk factors linked to suicide at a population level to provide early intervention and tailored support.
- Promoting online safety and responsible media content to reduce harms, improve support and signposting, and provide helpful messages about suicide and self-harm.
- Providing effective crisis support across sectors for those who reach crisis point.
- Reducing access to means and methods of suicide where this is appropriate and necessary as an intervention to prevent suicides.
- Providing effective bereavement support to those affected by suicide.
- Making suicide everybody's business so that we can maximise our collective impact and support to prevent suicides.

Suicide prevention in England: 5-year cross-sector strategy sets out over 100 actions led by government departments, the NHS, the voluntary sector and other national partners to make progress against these areas, particularly over the next 2 years.

3.2 The Wider Context

Considerable progress has been made since the last Suicide prevention strategy for England was published in 2012.

All areas of the country now have local suicide prevention plans and suicide bereavement services, supported by a £57 million investment through the NHS Long Term Plan[14]. New programmes of work have been established to tackle methods and improve the coverage of crisis and bereavement support, and collective efforts to improve patient safety have led to a 35% fall in suicides in mental health inpatient settings in England between 2010 and 2020.

Within the last 10 years, we observed one of the lowest ever rates of registered suicides (a rate of 9.2 registered suicides per 100,000 people, in 2017).

In 2018, there was an increase in the suicide rate following several years of steady decline. Although this was partly due to a change in the 'standard of proof' required for coroners to record a death as suicide, we know that other factors have played a part too. In 2022, 2 years on from the COVID-19 pandemic, provisional data suggested there were 5,275 deaths by suicide registered, a rate of 10.6 per 100,000 people.

And so, whilst the current suicide rate is not significantly higher than in 2012, the rate is not falling and there is much more we can do to prevent more suicides and save many more lives.

4.0 Understanding Risk

We know the factors leading to someone taking their own life are complex. For many people, it is the combination and interplay of risk and protective factors that is important rather than one single issue. These can affect us at an individual, relationship, community and societal level. For example, stigma, prejudice, harassment, and bullying can all contribute to increasing an individual's vulnerability to suicide. See Appendix 3 for detailed examples.

The national strategy highlights the following high-risk groups.

- children and young people
- middle-aged men
- people who have self-harmed
- people in contact with mental health services
- people in contact with the justice system
- autistic people
- pregnant women and new mothers.

Common risk factors linked to suicide at a population level have been identified nationally, alongside other stressful life events which need early intervention and tailored support. These include:

- Physical illness
- Financial difficulty and economic adversity
- Gambling
- Alcohol and drug misuse
- Social isolation and loneliness
- Domestic abuse.

We know that that there are some other groups that are at elevated risk of suicide, but we have limited evidence or understanding of how specific issues relating to these groups should be addressed.

There is national ambition for more comprehensive research on, and better understanding of, trends and suicide rates in particular groups, including:

- occupational groups
- autistic people
- people affected by domestic abuse.
- people experiencing harmful gambling.
- ethnic minority groups including people who are Gypsy, Roma or Travellers
- refugees and asylum seekers
- people who are LGBT

5.0 Groups at Higher Risk

5.1 Children and young people

Concern has grown for children and young people as the numbers of suicides have risen. Suicide in the under 20s has seen increases for a decade[15]. In 2019 in England, there were 565 suicides registered under the age of 25. Whilst the number of suicides in children and young people remains relatively small in Sussex, the numbers in younger age groups are increasing, matching national trends.

A recent UK-wide study[16] of suicide deaths in young people aged 10-19 years, reported antecedents such as witnessing domestic abuse, bullying, self-harm, bereavement (including by suicide) and academic pressures. Overall, 60% of those young people who died by suicide, had been in contact with specialist children's services.

Self-harm rates have also been rising in children and young people[17].

The change in rates of suicide amongst young people is mirrored by increasing rates of hospital admissions for self-harm in the same age (10 to 24 years), particularly for young females.

What we know about suicide issues in children and young people[18]

- 52% of suicides in under 20's reported **previous self-harm**.
- **Events in childhood** impact negatively on health in adulthood (physical and mental health), reducing the impact will help reduce young people and adult suicides.
- **Trauma, including suspected or confirmed cases of abuse,** neglect, and domestic abuse, was seen in more than a quarter (27.1%) of children who died by suicide.
- **Family-related problems**, such as divorce, custody disputes, parental substance use, or a family history of suicide or mental health concerns, were seen in more than a third (39.8%) of children who died by suicide.
- **Bereavement** was a specific issue for young people with 25% of under 20's and 28% of 20–24-year-olds experiencing bereavement.
- **Looked After Children** were a population group accounting for 9% of suicides in under 20's, with specific issues highlighted around housing and mental health.
- Of suicides in under 20's, 8% had experience of the **care system**[19]
- 6% of suicides in under 20's occurred in **lesbian, gay, bisexual, and transgender (LGBT) people** of whom one quarter had been **bullied.**
- **Suicide-related internet use** was found in 26% of deaths in under 20s.
- **Students under 20** more often took their lives during April and May linked to academic pressures.

- **Mental health concerns** were identified in a third (31.4%) of the suicide deaths examined, with the most common diagnoses being attention-deficit/hyperactivity disorder (ADHD) or depression. One study of deaths by suicide in those under the age of 20 found that 15% had a **mental illness**[20].
- **Physical health condition** was identified in 30% of deaths by suicide in those under the age of 20[21]
- **ADHD** is a neurodevelopmental condition along with Autism Spectrum Conditions. Both have a significantly increased risk of suicide ideation, self-harm, attempted suicide, and death by suicide. Co-morbidities such as extreme levels of anxiety, depression and being the victim of severe bullying are common.

Looked after children and care leavers have an especially increased suicide risk[22].

Location	Rates of Looked After Children in Sussex (2022)	Number of Looked After Children in Sussex (2022)
East Sussex	62 per 100,000	628
West Sussex	49 per 100,000.	860
Brighton and Hove	82 per 100,000	389
South East	56 per 100,000	
England	70 per 100,000	

Source Fingertips 2022

While ONS statistics suggest that higher education students in England have lower suicide rates[23] compared with the general population of similar ages, given the range of unique challenges and stresses associated with the transition into higher education, tailored support for university students is essential for preventing suicides.

5.2 Men (including middle-aged men)

In the UK, the suicide rate of men is three times higher than that of women (a trend that is similar across the western world). Over the past decade, middle aged men in their 40s and 50s have had the highest suicide rates of any age or gender[24].

Socioeconomic disadvantage is strongly associated with suicide among this demographic and middle-aged men did not have the highest rates of suicide of any group until after the 2008 recession, suggesting a link between recession and suicides.

Middle-aged men, living in the most deprived areas, face even higher risk with suicide rates about three times those in the least deprived areas.

A history of alcohol or drug misuse, contact with the justice system, family or relationship problems, and social isolation and loneliness are also factors that are common in men who died by suicide[25].

A study published in 2021 of men aged 40 to 54 who died by suicide in the UK[26] found that two thirds had been in contact with frontline agencies or services in the 3 months before their death. Most had been in contact with primary care services (43%), and contact had also been made with mental health services and the justice system, among others.

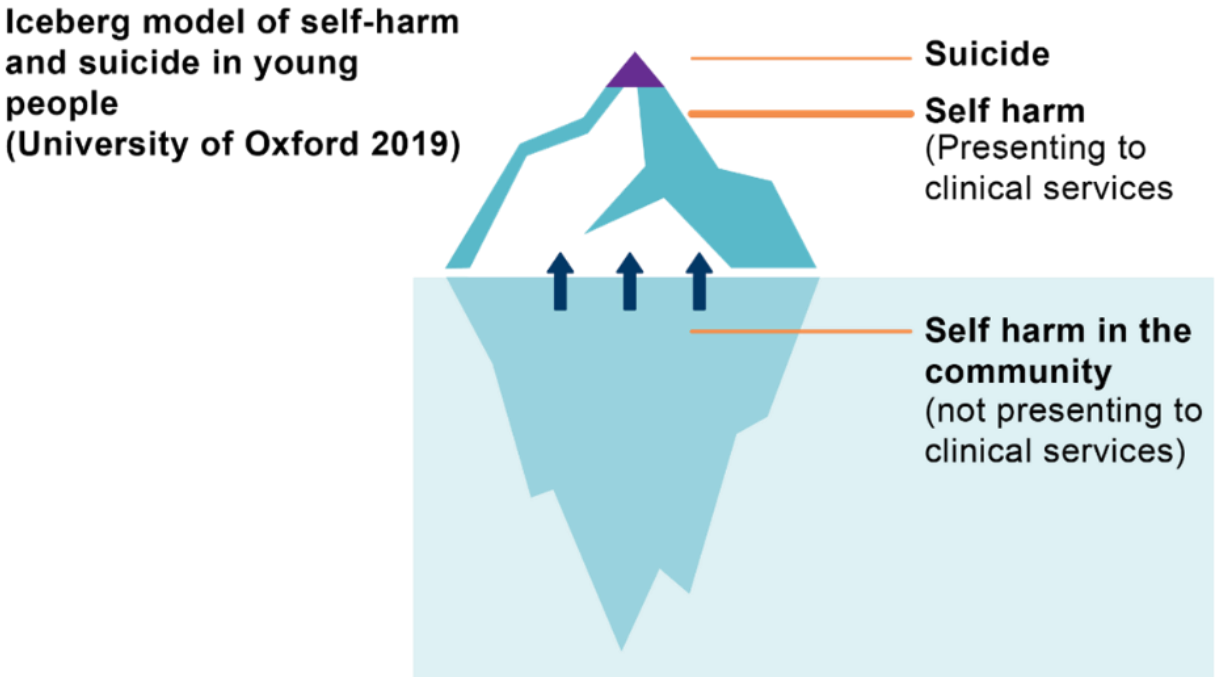
Men make up over 90% of the prison population[27].

5.3 People who have self-harmed

Self-harm, the deliberate action of causing physical harm to oneself is a clear sign of emotional distress. The relationship between self-harm and suicide is complex. In many cases self-harm is used as a non-fatal way of coping with feelings and stressors, particularly in young people. Nevertheless, self-harm is the single biggest single indicator of suicide risk.

Rates of self-harm in the community have risen since 2000, especially in young people. Each year, there are an estimated 200,000 hospital attendances for self-harm in the UK[28].Most incidences of self-harm occur in the community and do not lead to hospital attendance:

'Iceberg model': People with a history of self-harm



The occurrence of self-harm in the community is likely to be much higher. Evidence also suggests that the suicide rate is highest in the year following hospital discharge[29] for self-harm, particularly in the first month.

Self-harm in Sussex

Rates of self-harm in each local authority area in Sussex (as measured using hospital admissions for serious self-harm) are higher than the England average:

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	93,895	163.9	162.8	164.9
Sussex	–	-	-	-	-
Brighton and Hove	–	885	284.1	265.3	303.8
East Sussex	–	1,240	250.3	236.4	264.8
West Sussex	–	1,575	189.2	179.9	198.9

Source: Hospital Episode Statistics (HES), NHS Digital, for the respective financial year, England. Hospital Episode Statistics (HES) Copyright © 2023, Reused with the permission of NHS Digital. All rights reserved. Local Authority estimates of resident population, Office for National Statistics (ONS) Unrounded mid year population estimates produced by ONS and supplied to Office for Health Improvement and Disparities Local Authority estimates of resident population, Office for National Statistics (ONS) Unrounded mid-year population estimates produced by ONS and supplied to the Public Health England. Analysis uses the single year of age grouped into quinary age bands, by sex.

Evidence suggests that around 50% of people who die by suicide have previously self-harmed[30]. This risk is particularly heightened in the first year after self-harm, especially the first month. At least one person in every 100 who ends up in hospital after a suicide attempt will eventually die by suicide within a year, and up to five per cent do so over the following decade[31].

5.4 People with mental illness, including those in the care of mental health services.

80-90% of people who attempt/die by suicide have a mental health condition, but not all are diagnosed.[32] There is approximately an 8-fold increase in risk of suicide for people under mental health care for mental illness[33]. In the case of depression, on average, the risk of suicide is about 15 times higher than the average for the general population[34]. However, this is likely to be an underestimate, as many who die by suicide may not have been diagnosed.

People known to be in contact with mental health services represent around 27% of all deaths by suicide in England[35] – on average around 1,300 people each year. This includes anyone in contact with mental health community services, people in inpatient settings, and anyone that has been in contact with these services within 12 months.

Although this number has remained steady in recent years, the actual rate has been falling as the numbers of people coming under mental health services has been increasing. The rate of suicides in in-patient settings is also falling.

This fall is likely due to safer physical environments (including the removal of ligature points), staff vigilance, and wider improvements in mental health inpatient settings.

Of all people that had been in contact with mental health services who died by suicide in England, nearly half (48%) had been in contact with mental health services within 7 days

before their death[36]. A large proportion (82%) of patients that died by suicide in England were assessed to be at 'low' or 'no risk' of suicide in short-term risk assessments before their death.

We must also continue to explore opportunities to better support those with specific diagnoses of conditions associated with higher rates of suicide by working with policy, clinical and personal experience experts to provide bespoke suicide prevention activity where needed.

DHSC, with NHSE, intend to explore opportunities to improve the quality of care for patients with these diagnoses and ensure compliance with NICE guidelines. This includes patients diagnosed with:

- affective disorders, including depression and bipolar, who accounted for 42% of all patient suicides in England between 2010 and 2020[37]
- personality disorders, who accounted for 11% of all patient suicides in England between 2010 and 2020 (and this figure is increasing) [38]
- schizophrenia and other delusional disorders, who accounted for 16% of all patient suicides in England between 2010 and 2020[39]
- eating disorders, where one-quarter to one-third of people diagnosed with anorexia nervosa and bulimia nervosa have attempted suicide. NHSE continues to work with systems and healthcare professionals to support the adoption of guidance from the Royal College of Psychiatrists on medical emergencies in eating disorders[40]

5.5 People in contact with the criminal justice system

People in contact with the criminal justice system are five times more likely to die from suicide than those who have no criminal justice system exposure.[41] This is, in part, because the life trajectories of many people in contact with the criminal justice system are characterised by chronic instability, abuse, neglect, and intergenerational disadvantage, all of which increase the risk of suicidal thoughts and behaviours.

Men make up over 90% of the prison population[42].

5.6 Neurodivergent Individuals

Neurodiversity refers to the different ways the brain can work and interpret information. It highlights that people naturally think about things differently. We have different interests and motivations and are naturally better at some things and poorer at others.

Most people are neurotypical, meaning that the brain functions and processes information in the way society expects.

However, it is estimated that around one in seven people (more than 15 per cent of people in the UK) are neurodivergent, meaning that the brain functions, learns and processes

information differently. Neurodivergence includes a range of conditions including Attention Deficit Disorders, Autism, Dyslexia and Dyspraxia.[43]

Neurodivergent individuals may also face additional barriers when trying to access mental health support and resources, including the lack of neuro-affirmative practices and challenges in understanding the needs of neurodivergent people.

Neurodivergent individuals may also face barriers in gaining support to access employment or to remain in employment. Such support is available through Access to Work and specifically specialist work-based coaching[44].

There is emerging evidence that ADHD is also significant indicator for suicide risk. Research looking at 372 coroners' inquest records, from 1 January 2014 to 31 December 2017 in two regions of England, found that 10% of those who died by suicide had evidence of elevated autistic traits, indicating likely undiagnosed autism[45]. This is 11 times higher than the rate in people without autism in the UK. ADHD is also associated with significantly elevated risk of suicide[46]. Evidence also indicates that neurodivergent individuals are over-represented in the other high-risk groups - homeless, substance misuse and gamblers.

Neurodivergent individuals can be exposed to certain social and emotional challenges and may struggle with unexpected change, social interactions, communication, and emotional regulation, which can also lead to feelings of isolation, loneliness, and despair. The increased risk may also relate to social stigma, discrimination, bullying, and marginalisation in society.

Neurodivergent individuals may also face obstacles in gaining support to access employment or to remain in employment. Such support is available through Access to Work and specifically specialist work-based coaching.

These problems are especially relevant for the 9,500 (approximately) people on the waiting lists for a diagnostic assessment with the neurodevelopmental services in Sussex.

5.7 Autistic People

Evidence suggests autistic people, including autistic children and young people[47], may be at a higher risk of dying by suicide compared with those who are not autistic.

Undiagnosed or late-diagnosed autism may be a preventable risk factor for suicide[48] and, therefore, earlier identification and timely access to autism assessment services is vital.

Specific factors that further increase the risk of suicide among autistic people include traumatic, painful life experiences[49], barriers to accessing support[50], pressure to 'camouflage' or 'mask' autism[51] (for example, concealing particular traits that are common in autistic people) and feelings of not belonging[52]. Autistic people report difficulties in accessing mental health support[53] because they have an autism diagnosis, are awaiting autism assessment or because of a lack of reasonable adjustments to services.

5.8 Pregnant women and new mothers

In the UK, suicide is the leading cause of direct deaths 6 weeks to a year after the end of pregnancy[54]. In 2020, women were 3 times more likely to die by suicide during or up to 6 weeks after the end of pregnancy compared with 2017 to 2019. Impacts on affected families are devastating and often have lasting effects, particularly on children from a very early stage in their development.

Overall, the level of risk of suicide after pregnancy is not higher than at other times in a woman's life. However, the high risk compared with other causes of maternal death (most of which are rare) and the potential long-term consequences on children's development mean we must take action to prevent suicides in this group. The increasing numbers of teenage maternal suicides, in particular care leavers, in recent years is a significant concern and particular targeted support is needed for this age group.

Perinatal mental illness affects up to 27% of new and expectant mothers[55] and is linked to suicide.

5.9 People with Physical illness

Evidence suggests that a diagnosis of a severe physical health condition may be linked to higher suicide rates[56]. Evidence from NCISH suggests that over half of men aged 40 to 54 who died by suicide had a physical health condition[57].

And, while 2 of 3 people who die by suicide have not been in contact with mental health services within the previous year, evidence suggests that many (49 to 92%) make contact with primary healthcare services in this time[58]. Over 40% of middle-aged men have been in contact with primary care services[59] for either physical or mental health needs within 3 months before taking their own life. It is essential that we support those seeking help for physical illness to meet both their physical and mental health needs.

5.10 People who are economically vulnerable

Financial difficulty and adversity can result in suicidal thoughts or action. Evidence shows an increased risk of suicide for people with debt, and economic recession has been consistently linked to suicide[60]. More recently, evidence from charities such as Money and Mental Health has suggested that rises in the cost of living have been linked to some people feeling unable to cope[61], with some feeling suicidal.

People amongst the most deprived 20% of society are more than twice as likely to die from suicide than the least deprived 20%[62].

History tells us that financial stressors can impact suicide rates-it is estimated that during the recession of 2007 there was an excess of 10,000 suicide deaths in European countries, Canada, and USA[63]. During the same period there was a 0.54% increase in suicides for

every 1% increase in indebtedness across 20 European countries, including the UK and Ireland[64]. Men in mid-life were particularly vulnerable.

There is also a strong relationship between unemployment and suicide in men-during the last recession there was a 1.4% rise in suicide rates for every 10% increase in unemployment in men[65].

Post Covid-19 pandemic, new issues are emerging such as debt linked to fuel poverty and increasing 'cost of living' pressures which may impact those already in financially unstable circumstances, particularly in the poorest areas of the country.

5.11 Victims and witnesses of domestic abuse and violence

Since the 2012 national strategy, more evidence on a link between domestic abuse and suicide[66] has emerged. Research on intimate partner violence, suicidality and self-harm[67] showed that past-year suicide attempts were 2 to 3 times more common in victims of intimate partner violence than non-victims. It highlighted deaths in male and female victims, children and young people in households impacted by domestic abuse, and among perpetrators. Research by the Kent and Medway Suicide Prevention Programme and Kent Police[68] found around 30% of all suspected suicides in that area between 2019 and 2021 were impacted by domestic abuse.

Suicide rates are higher in both the victims and perpetrators of domestic abuse and violence. 50% of those people who have had a suicide attempt in the past year had experienced intimate partner violence at some point in their lifetime[69].

5.12 People with high-risk gambling behaviours

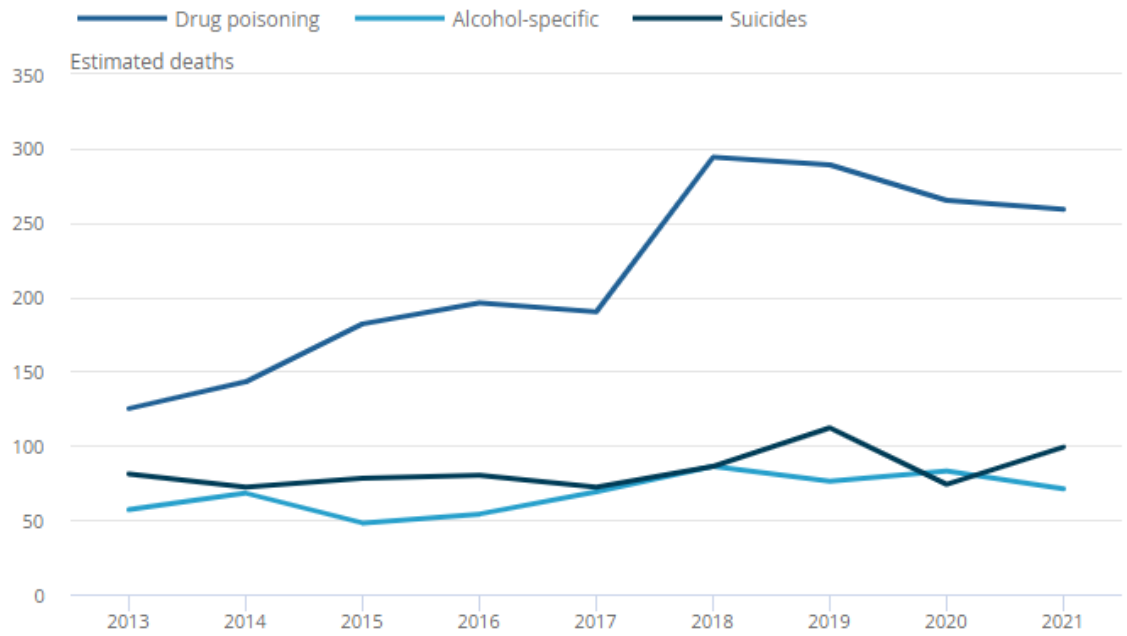
There is increasing evidence of the relationship between harmful gambling and suicide, including in younger people[70]. Although reasons for suicide can be complex, we do know that gambling can be a dominant factor without which the suicide may not have occurred. Action therefore needs to be taken to address the harms of gambling, including suicide, and reach people at risk.

Gamblers who report high-risk gambling behaviours are at increased risk of suicidality. A Swedish study, for example, reported the risk of suicide in a cohort of more than 2000 people with diagnosed gambling disorder was 15 times the rate in the general population[71].

5.13 Homeless People

People who are homeless have a higher proportion of mental disorders than people with stable accommodation, particularly psychotic illness, personality disorders and substance misuse[72]. Suicide is the second most common cause of death among people who are

homeless or rough sleepers in England and Wales, accounting for 13% of deaths among homeless people or rough sleepers in 2018.[73].



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5.14 People who misuse substances

People who abuse alcohol and drugs experience greater than average economic disadvantage, debt and unemployment, social isolation, and other complex needs, and have higher rates of mortality and morbidity.

Collectively, substance use disorders confer a risk of suicide that is 10–14 times greater than that of the general population; deaths related to substance use are highest among people with alcohol use disorders followed by persons who abuse opiates[75].

People who are dependent on alcohol are approximately 2.5 times more likely to die by suicide than the general population[76]. In England, nearly half (45%) of all patients under the care of mental health services who die by suicide have a history of alcohol misuse, accounting for 545 deaths per year on average[77].

Acute intoxication[78], as well as dependence on alcohol and/or drugs, has been consistently associated with a substantial increase in the risk of suicide and self-harm.

Addressing alcohol and drug use may be especially important for supporting particular groups. In a study of middle-aged men that died by suicide in 2017, 49% had experienced alcohol misuse, drug misuse or both[79], particularly where individuals were unemployed, bereaved or had a history of self-harm or violence. Among people in contact with mental health services in England who died by suicide between 2010 and 2020, there were high proportions of both alcohol misuse (45%) and drug misuse (35%)[80].

Mental health trusts that implemented a policy on co-occurring drug and alcohol use observed a 25% fall in patient suicides[81].

5.15 Loneliness and social isolation

Social isolation (having few people to interact with regularly) and loneliness (not having the quality or quantity of social relationships we want, regardless of social contacts) have been closely linked to suicidal ideation and behaviour[82].

Loneliness is also associated with increased suicidality and self-harm. Those with severe loneliness are 17 times more likely to have made a suicide attempt in the past 12 months[83].

One study suggested that social isolation was experienced by 15% of under-20 year olds and 11% of 20 to 24 year olds who died by suicide[84], and qualitative research undertaken by Samaritans[85] found loneliness played a significant role in young people's suicidal thoughts or feelings. A further national study suggested that, of men aged 40 to 54 who died by suicide, 11% reported recent social isolation[86].

We know that loneliness is one of the primary reasons that individuals access crisis services, and that actions to reduce social isolation and loneliness are therefore likely to be key to suicide prevention[87].

5.16 LGBTQ+ Community

People from the LGBTQ+ community are being highlighted as a group at increased risk of suicide in the forthcoming national suicide prevention strategy. Although this risk depends on age, sexual orientation etc, people from LGBTQ+ groups have higher than average levels of mental illness, suicidality[88] [89]and completed suicide as well as facing increased levels of discrimination, stigma, social exclusion, and poor access to bespoke services[90].

In the 2021 Census, 1 in 200 adults aged 16+ in Sussex (0.5%) said that their gender identity was different from their sex registered at birth[91]. Rates varied from 1 in 100 in Brighton & Hove, 1 in 250 adults in East Sussex and 1 in 300 in West Sussex.

A review of several studies found increased suicide risk in LGB+ adults with up to 20% attempted suicide in their lifetimes.[3] 46% of transgender people and 31% of LGB+ cisgender people reported suicidal thoughts in the last year.[92]

5.17 Military Veterans

There are comparatively few international studies investigating suicide in military veterans but a recent study in the UK investigated the rate, timing, and risk factors for suicide in personnel who left the UK Armed Forces (UKAF) over a 22-year period (1996 to 2018)[93]. This found that overall suicide risk in veterans was comparable to the general population but there were important differences according to age, with higher risk in young men and

women. Several factors increased the risk of suicide, but deployment was associated with reduced risk.

5.18 Ethnic Minorities

Black and racially minoritised groups - rates of suicide were highest in the White and Mixed/Multiple ethnic groups for both men and women[94]

Gypsy Roma Traveller communities – the evidence is that Gypsy, Roma, Traveller and nomadic communities are at increased risk. The suicide rate for Irish Traveller women is six times higher than the general population, and seven times higher for Irish Traveller men.[95]

5.19 Occupations

Analysis of 2011[96] Census data demonstrates different risk profiles amongst different occupations for example, men working in the lowest-skilled occupations had a 44% higher risk of suicide than the male national average. The risk among men in skilled trades was 35% higher than the average. Individuals working in roles as managers, directors, and senior officials – the highest paid occupation group – had the lowest risk of suicide. Among corporate managers and directors, the risk of suicide was more than 70% lower for both sexes[97].

The risk of suicide was elevated for those in culture, media, and sport occupations for males (20% higher than the male average) and females (69% higher than female average). There is also higher risk in some health professional groups.

6.0 What is effective in suicide prevention?

There are many ways in which services, communities, individuals, and society can help to prevent suicides. A key message from practice and research is that collaborative working is key. Partnership approaches working with, and within local communities, aiming to protect those who are most vulnerable are vital to reducing risk.

An approach that combines mitigating risk factors and enhancing protective factors is more likely to be successful. It is also important to look at suicide prevention across the life stages, from children and young people to adults, and to base any actions on national and local evidence to identify areas of focus to inform the actions that will be needed.

6.1 Addressing Risk Factors

Early intervention is prioritised, with different sectors and government departments addressing risk factors with a strong link to population-level suicide and self-harm rates.

There is strong collaboration within ICSs, building on existing successes that bring a wide range of partners together to address risk factors and wider determinants linked to suicide prevention, such as housing and financial difficulty.

All local suicide prevention plans include tangible actions to address risk factors at a local level.

People who work in relevant public services are supported to identify and support people who might be at risk of suicide or self-harm.

As well as reducing risk factors and enhancing protective factors in the longer term, it is vitally important that we support those at immediate risk.

6.2 Providing Effective and Appropriate Crisis Support

- It is essential that timely and effective crisis support is available to those who need it.
- Only a minority of people who have suicidal thoughts/impulses take their lives.
- Many people in distress don't seek help/support on their own, therefore identify people at risk, reach those in the greatest need, connect them to care/support.
- Empower people to recognise when they need support and help them to find it
- With the right help people can get through a suicidal crisis and recover.
- Recognise that 'hopelessness' is a strong predictor of suicide combined with suicidal ideation without a credible safety plan.
- Anything that delays or disrupts a suicidal act can be lifesaving (including limiting access to the means of suicide), can interrupt suicidal intention, buy time for individual to reconsider and/or be helped.

6.3 Tackling Means and Methods of Suicide

Improving early intervention and tackle the drivers of self-harm and suicidality are vital, but only part of the overall picture, because we know there will still be individuals who may be contemplating and planning suicide. For people at this point, one of the most impactful practical interventions is to reduce access and limit awareness of the means and methods of suicide, providing more time to intervene with effective longer-term actions and preventative support.

Cross-government and cross-sector partnership working continues. There is work to monitor common and emerging methods of suicide and high-risk locations, and ensure that appropriate action is taken in a timely manner as new intelligence becomes available.

First responders and people working on the frontline need to feel equipped to respond appropriately to deaths by potential suicide, no matter the method used, and have the skills necessary to adapt to the situation they find themselves in.

There are continued efforts to ensure that there is responsible reporting of the methods used in suspected or confirmed suicide cases in the media. Information about methods of suicide should be as restricted as possible in the public eye.

Robust reporting systems and mechanisms are in place to enable partners working in high-risk locations to share data and best practice with colleagues to ensure that effective interventions can be replicated across the country.

Around a third of all suicides take place outside the home. High-frequency locations are public sites that are frequently used as a location for suicide. We would encourage those with a role in the planning system to consider the risks of suicide associated with buildings and public spaces and to consult the practice resource 'Preventing suicides in public places'[98] when creating local design policies.

The effectiveness of interventions for reducing access to certain high-frequency locations[99] has been well evidenced. For example, the construction of safety barriers has been shown to successfully reduce suicides on particular bridges. However, these interventions should always go hand in hand with additional measures, including help from others, increasing opportunities for help-seeking, and addressing awareness and reputation of specific locations as a 'suicide site'.

Beachy Head in East Sussex has the highest frequency of deaths at a single location in the UK and presents specific challenges for prevention, most notably its size, remoteness and the fact that the vast majority of those completing suicide there travel from out of county.

6.4 Providing Timely and Effective Bereavement Support

Evidence suggests family, friends and acquaintances who are bereaved by suicide may have a risk of dying by suicide that is up to 3 times higher than the general population. Compassionate, effective and timely support for people bereaved by suicide is essential.

Local authorities, police, national government, coroners, the NHS, schools and universities, and VCSE organisations all have an essential role in providing effective and timely bereavement support.

Our ambition and vision is:

- there is widespread recognition that improving bereavement support is an important goal in its own right, and bereavement is a risk factor for suicide among family, friends and acquaintances.
- all individuals bereaved by suicide are offered timely, compassionate and tailored support, wherever they live.
- across workplace, education and health settings, there is recognition of the impact of a suicide bereavement on families, carers, loved ones and the wider community, and actions are taken forward to provide access to support.

- understanding of the impacts of suicide bereavement on groups (including children and young people, people who are LGBT, and ethnic minority groups) is strengthened through research and personal experience insight.

People bereaved by suicide should receive effective support and services following a suicide, regardless of where they live.

Bereavement services and support should consider the needs of different groups and communities to ensure a wide range of people receive the support they need. These different groups include:

- People personally bereaved by suicide.
- University students
- Minority ethnic groups
- Bystanders and witnesses to suicide

6.5 Making Suicide Everyone's Business

Suicide prevention is everyone's business. Every person, organisation and service across the county has a role to play. In recent years, good progress has been made to tackle the stigma surrounding suicide and mental health. However, there is more we can all do to ensure we are all equipped with the skills necessary to potentially save lives.

- every individual across the county has access to training and support that gives them the confidence and skills to save lives. Training is routinely promoted, with significant numbers of people trained in suicide prevention.
- there is no wrong door – when people experiencing suicidal thoughts or feelings reach out, they receive timely support, no matter what service the individual initially accesses. Systems and services are connected around individual's needs.
- employers (especially those in high-risk occupations) have appropriate mental health and wellbeing support in place for their staff – learning from and building on the work the NHS and others are undertaking. This includes members of staff being trained in suicide prevention awareness, particularly those interacting with people who may be more vulnerable.
- we work in partnership so that everyone - from individuals through to organisations and services – feel responsible for ensuring that they are consistently using language that supports people while reducing shame and stigma. This supports everyone to feel able to seek support whenever they need it.

6.6 Improving Skills and Knowledge

Crucial to these ambitions is ensuring everyone has the skills, knowledge and confidence to provide necessary support and intervention. The availability and promotion of easy-to-access guidance and training for everyone is a vital first step.

A range of suicide prevention awareness training courses are already available for both individuals and organisations, including from charities such as Samaritans, and PAPYRUS. This includes free, online courses such as those provided by the Zero Suicide Alliance.

It is also vital that, collectively, we do all we can to reduce stigma. Stigma can be a barrier to people seeking support when they are feeling suicidal or looking for bereavement support. Everyone has a role in creating safe spaces for people to speak up and seek support. Using language that reduces shame and stigma, and encourages people to seek support is an important step everyone can take.

There have been great examples of campaigns, resources and action that support delivering this. Many have been led by people with personal experience of suicide and bereavement, whose bravery and perseverance in making positive change for the good of society, following such a personal tragedy, is incredibly admirable.

As an example of this, If U Care Share is committed to raising awareness of the importance of suicide prevention and postvention, and offering professional support to individuals. As part of this, it has developed resources in collaboration with people with personal experience to dispel the myths surrounding suicide and facilitate open conversations.

Organisations such as the National Suicide Prevention Alliance bring together individuals and organisations from a range of sectors, including people with personal experience. They provide resources and support to help ensure suicide prevention becomes everyone's business.

6.7 The Role of Employers

Employers have an essential role to play in supporting practices and conversations that help prevent suicides. There are multiple ways this can be done – for example, through employment assistance programmes, line manager training or peer support networks.

While this is imperative for workers engaging with more vulnerable members of the public, every employee should feel supported and every employer should ensure that support is known and available.

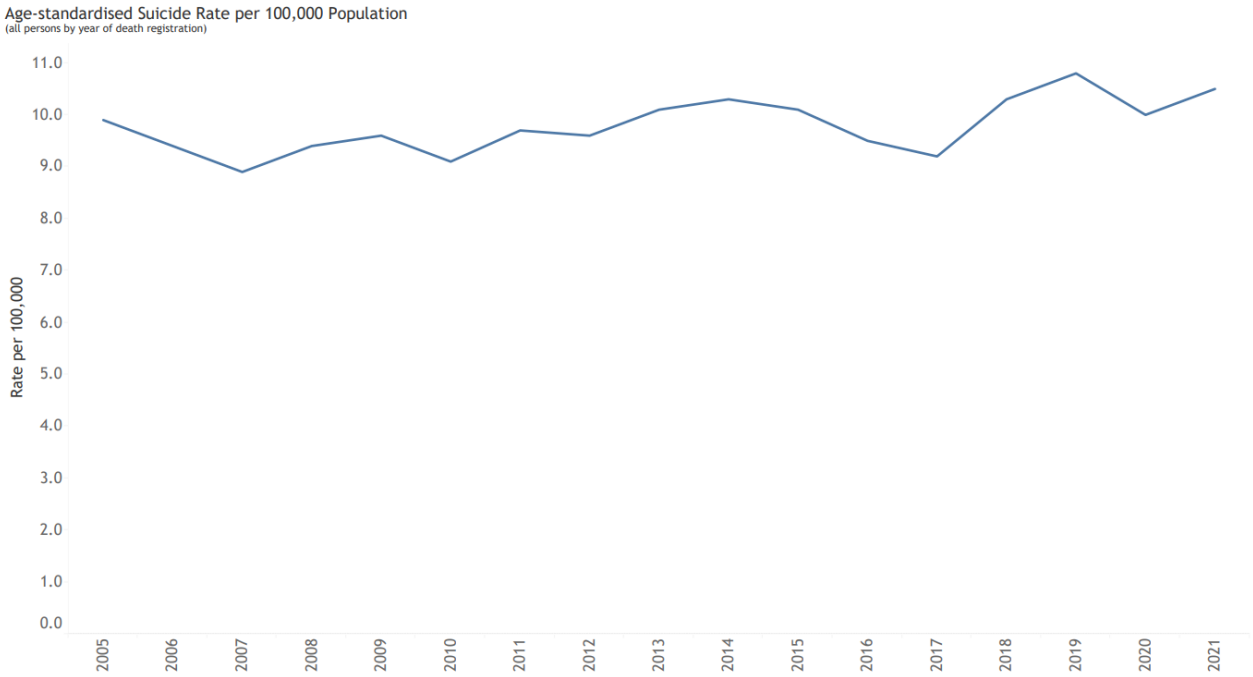
We strongly encourage all employers to have adequate and appropriate support in place for employees, such as people trained in mental health first aid, mental health support and suicide prevention awareness. Employers should also encourage employees to take the time to look after their mental health, focusing on prevention as well as providing support.

7.0 Data

7.1 The National Picture incl. National Data:

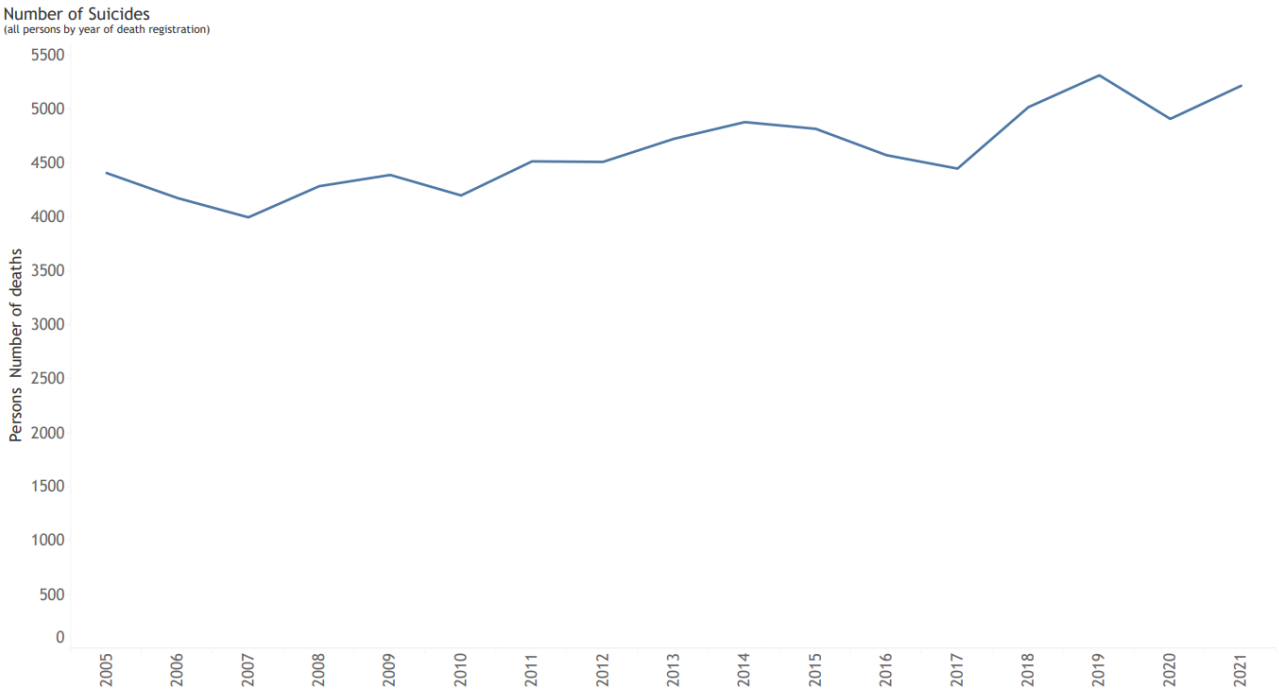
Between 2013 and 2018 suicide rates in England had been steadily reducing and although now rising again are low in comparison to those of most other European countries. Prior to the Covid-19 pandemic there were already concerns about the rising rate of suicide in 2018 and 2019 (see **Figures 1 and 2**). The high rates in middle age and after self-harm were also noted as national priorities[1]. Suicide in the under 20s has seen increases for a decade.

Figure 1: Number of suicide deaths registered in England.



[1] Preventing suicide in England: Fifth progress report of the cross-government outcomes strategy to save lives (publishing.service.gov.uk)

Figure 2: Age-standardised rate for registered suicide deaths in England



While the exact reasons for the 2018 increase are unknown and could include changes to the recording of deaths by suicide, the latest data shows that the rise was largely driven by an increase among men-who have continued to be most at risk of dying by suicide. In recent years, there have also been increases in the rate among young adults, with females under 25 reaching the highest rate on record for their age group. Overall, people aged 10 to 24 years, and men aged 45 to 64 years have seen the greatest increases in suicide rates.

In 2022, 2 years on from the COVID-19 pandemic, provisional data suggested there were 5,275 deaths by suicide registered[100], a rate of 10.6 per 100,000 people. And while, overall, the current suicide rate is not significantly higher than in 2012, the rate is not falling.

7.2 Suicides in Mental Health Inpatient Settings

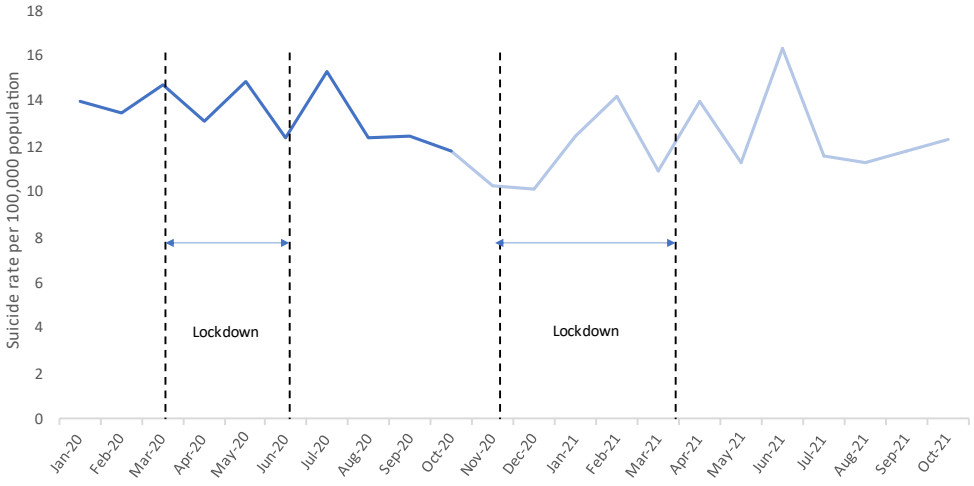
Collective efforts to improve patient safety led to a 35% fall in suicides in mental health inpatient settings in England between 2010 and 2020[101].

7.3 Impact of Covid Pandemic on National Suicide Rates and Trends

After increases in the national suicide rate in 2018 and 2019, there were additional concerns relating to Covid-19, centred on potential risks to mental health-from anxiety, isolation, loss of support and disruption to care. However, the overall national rate in 2020 decreased to 10 per 100,000 from 10.8 in 2019 and there were no rises over lockdown

(Figure 3). This also tallies with international data, which can provide us with some confidence that UK analysis is accurate.

Figure 3: Suicide rates over covid-19 lockdowns



No rise in the number of suspected suicides

This finding is **reflected** in ONS findings

The cross-government report on preventing suicides in England and the 2022 National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH)[102] annual report indicated that whilst the pandemic did indeed cause concern, some of the actions taken may have had some protective elements. More support for crisis services, more community engagement, family time and support specifically at the beginning of the pandemic, may have provided some element of protection.

'Perhaps the explanation is social cohesion, mutual support, a sense of getting through it together. Perhaps friends and families have rallied around those who are vulnerable. Perhaps the pandemic brought out the best in us'-Louis Appleby.

Nevertheless, continued vigilance and targeted actions are vital as COVID-19 has exposed fault lines in society where risk of suicide is also found - inequalities based on deprivation, ethnicity, disability, and stigma worsened during the pandemic.

The post Covid-19 period may be particularly challenging times for vulnerable individuals and the impacts may be longer term: particularly in those for whom the pandemic has exacerbated existing problems, and for those for whom the pandemic has resulted in significant and specific new issues, that we know are potential drivers of suicide, for example, job loss, unmanageable or mounting debts because of reduced income, bereavement and loneliness or social isolation.

Groups that have been flagged nationally as needing additional vigilance include those who have experienced a negative financial impact, children, and young people, specifically those who self-harm, witness domestic abuse, experience bereavement, bullying and academic pressures; and those with existing mental health problems.

Post-Covid-19 we also need to monitor certain occupational groups that may have experienced significant trauma throughout the pandemic, such as those working in health and social care. They risk experiencing the negative enduring consequences of this trauma, including burnout.

Children's experience of Covid-19/lockdowns:

In the early stages of the Covid pandemic, NHS England alerted clinicians and services to a possible increase in children and young people suicides, including potential risks for those with autism spectrum disorder (ASD) or attention deficit hyperactivity disorder (ADHD).

Due to the pandemic, education and employment opportunities changed and many young people reported feeling overwhelmed with the pressure to maintain the high standards of their work whilst adapting to a new way of learning and working. For those coming out of education in particular, the prospects of finding a job and long-term employment have also been identified as a particular risk factor.

Amongst the likely suicide deaths in young people reported after the lockdowns, restriction to education and other activities, disruption to care and support services, tensions at home and isolation were found to be potentially contributing factors.

7.4 Local Data

Sussex has a combined population in the region of approximately 1.5 million, and ranges from very affluent areas to some of the most deprived in the country. There are inner city areas, coastal and rural communities, and everything in between.

Sussex is made up of three local government areas, East Sussex, West Sussex and Brighton and Hove, each with its own demographic and political make-up.

Table 1: numbers of suicides and rates of suicide across local authorities in Sussex

Location	Numbers (average over past 5 years)	Rate	Population
Brighton and Hove	36	14.1	277k
East Sussex	63	12.1	455k
West Sussex	75	11.5	843k
Total	174		

The rates of suicide in Brighton and Hove and in East Sussex consistently exceed the England average (Table 1 and Figures 4,5 and 6). The rate of suicide in West Sussex mirrors the England average:

Figure 4: Suicide rate (Persons) for Brighton and Hove

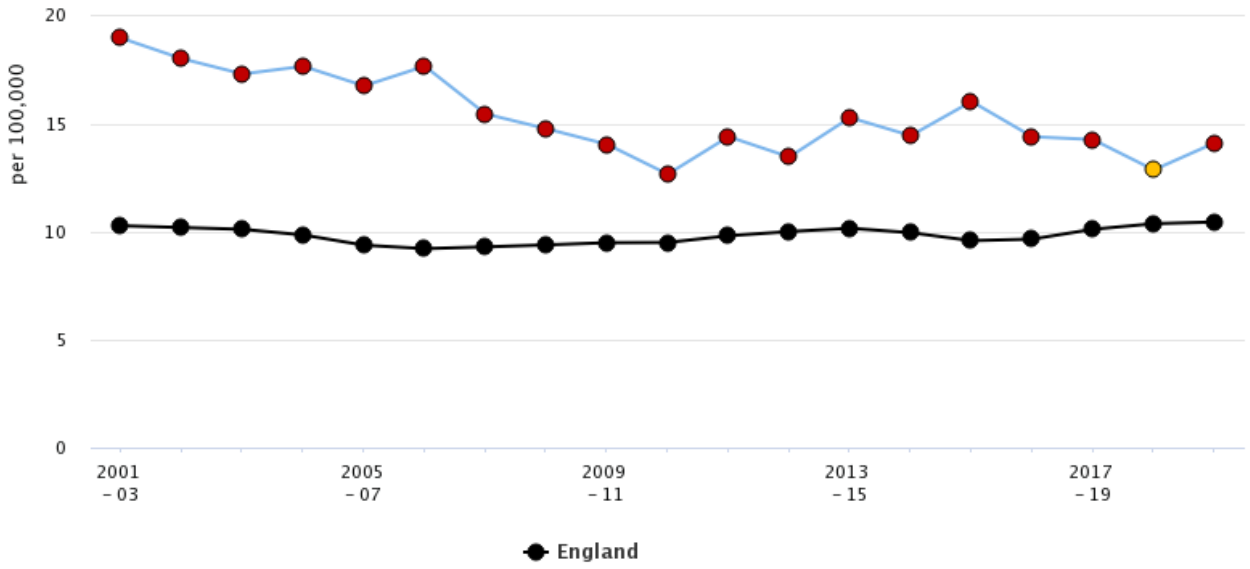


Figure 5: Suicide rate (Persons) for East Sussex

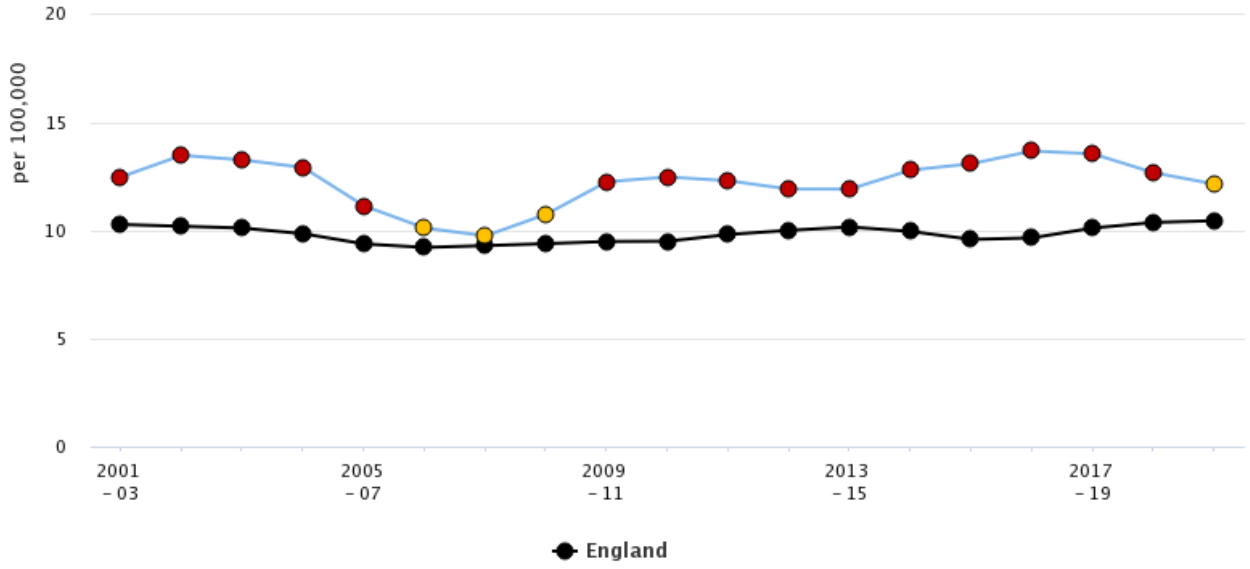
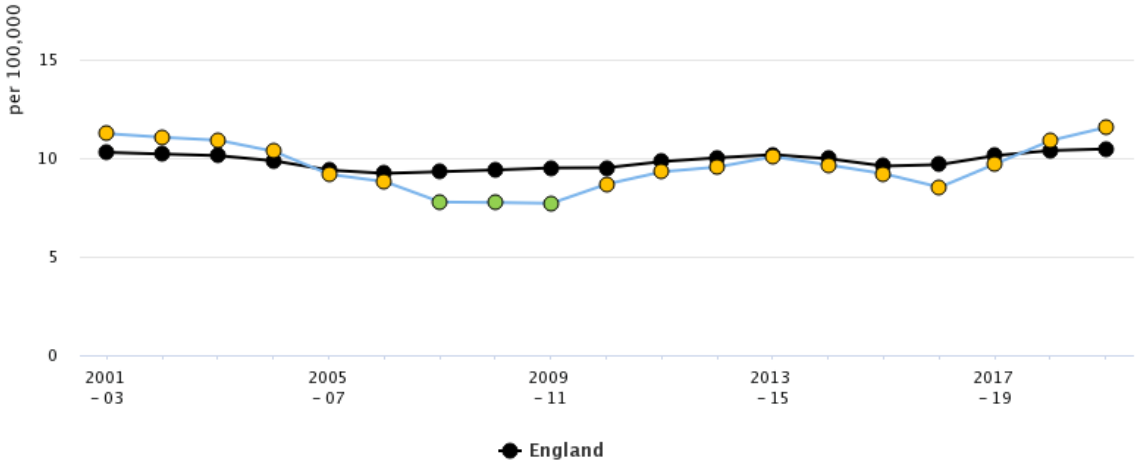


Figure 6: Suicide rate (Persons) for West Sussex



7.5 Surveillance (Real Time Surveillance)

Real-time surveillance is now available in Sussex. This is information gathered via police colleagues at the scene of an unexpected death which may be due to suicide. These suspected suicides have not yet gone through the coronial system, but they present important and timely information on local suicides.

The advantage of real time surveillance is it allows us to respond quickly to emerging trends that point to particular risk factors or high-risk groups locally. We can put in place prompt mitigations and the data also allows us to provide timely support to those who have been recently bereaved or affected by suicide.

8.0 Sussex Suicide Prevention Action Plan

8.1 How Do We Get There?

A key issue now is to ensure that our planning, partnership building, and data collection turn into action. The Action Plan, summarised below, covers the first year (2024). It will be updated and amended in response to the changing nature of risk factors for suicide and the continuous evaluation of our progress.

The Action Plan sets out areas for actions for key partners that will be best delivered at pan-Sussex level; some can be tackled immediately, others phased in over the lifetime of the strategy. It should be noted that progress with some is dependent on the availability of resources to do so.

The Action Plan will be monitored quarterly by the Sussex (ICS) Suicide Prevention Steering group.

8.2 How Will We Measure Success?

Ultimately, we want to see a reduction in Sussex's suicide rate. However, due to the relatively low numbers of suicides it is difficult to quickly show a statistically significant improvement in suicide rates across a local area. Therefore additional (proxy) measures will be used to assess the Plan's success. These measures include for example, levels of self-harm in the population and levels of activity across the action areas.

8.3 Sussex Suicide Prevention Strategy – One Year Action Plan 2023/24

*******Dependent on programme support capacity

Action Area	Key Actions	Lead(s)	Timescale
Working with Sussex-wide partners	Commitment of partners to Sussex Suicide Prevention Strategy Group and sub-groups	Director of Public Health, East Sussex County Council	Ongoing
	Endorsement of Sussex SP Strategy by 3x Health and Wellbeing Boards		
	Publication of Sussex SP Strategy		Nov 2023 – Jan 2024
	Publication of SPFT Suicide Prevention Strategy		Feb 2024
Suicide Response / Postvention	Establish 'postvention' working group to oversee,	Consultant in PH/ Programme Lead	***
	Develop system capacity to identify and support those affected by suicide in real time	Consultant in PH/ Programme Lead	***
	Continued development of RTS analytical/surveillance capability, dashboard and inclusion of self-harm, suicidal behaviour and drug related deaths	Consultant in PH	Ongoing
	Deliver Sussex Workforce Wellbeing Project		Ongoing
	Scope potential to expand GP based 'After Death Reviews'(ADR) capacity beyond Brighton and Hove	Clinical Director, NHS Sussex	March '23 – Sept '24

Action Area	Key Actions	Lead(s)	Timescale
	Undertake a Pan-Sussex bereavement health needs assessment (not limited to suicide bereavement) and develop business case for future bereavement support based on need.	Consultant in PH/ Programme Lead	***
Training / learning	Establish 'training/learning' working group to oversee,	Consultant in PH / Programme Lead	
	Undertake training needs analysis – with aim of scoping potential to organise and commission training across Sussex.		***
	Develop system capacity to share learning from statutory and non-statutory incident reviews, including CDOP, serious incidents, inquests and ADRs		***
Communications, Engagement with media and online safety	Co-ordinate communications, campaigns and working with media across Sussex	ICS Comms team	Ongoing
	Scope need for a web-based central resource and campaign portal		***
	Complete communications strategy relating to Coastal Suicides		Nov 2023
	Evidence reviews of online harms and develop recommendations for action		June 2024
Lived Experience	Establish 'lived experience' working group to oversee,	SPFT / Consultant in PH / Programme Lead	***
	Development of proposals to ensure a meaningful and sustainable approach to involving those with lived experience, in the design and delivery of suicide prevention activity		

Action Area	Key Actions	Lead(s)	Timescale
	Engage National Suicide Prevention Alliance (NSPA) to support local organisations and action develop Sussex lived experience local network.		
Self-harm	Continue Sussex Self-harm Learning Network and scope potential for Pan-Sussex strategic approach.	Consultant in Public Health	Dec 2023
	Develop self-harm prevention framework for children and young people, using the findings from local needs assessments		Jan -June 2024

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27.7.23

Amendments

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Nicola Rosenberg, Consultant in Public Health, West Sussex County Council

Neil Peters, Suicide Prevention Consultant, Nuthatch Consultants, working on behalf of Sussex Suicide Prevention Steering Group

20.10.23

Appendix 1- National frameworks, evidence, and resources

- Suicide prevention in England: 5-year cross-sector strategy (Department of Health and Social Care, 2023)
- Suicide prevention strategy: action plan (Department of Health and Social Care, 2023)
- Preventing suicide in England: A cross-government outcomes strategy to save lives, (Public Health England, 2012)
- Preventing suicide in England: Fifth progress report of the cross-government outcomes strategy to save lives (publishing.service.gov.uk)
- Preventing suicide in public places (Public Health England, 2015)
- Identifying and responding to suicide clusters and contagion (Public Health England, 2015)
- Suicide Prevention (House of Commons Health Committee, 2016).
- Government response to the Health Select Committee's Inquiry into Suicide Prevention (Department of Health, 2017)
- National Confidential Inquiry into Suicide and Safety in Mental Health (Healthcare Quality Improvement Partnership, 2019)
- National Confidential Inquiry into Suicide and Safety in Mental Health Annual Report (Healthcare Quality Improvement Partnership, 2023)
- Prevention concordat for better mental health (Public Health England, 2020)
- Support after a suicide: A guide to providing local services (Public Health England, 2016)
- Suicide Prevention, Resources and Guidance (Public Health England, 2019)
- Suicide Prevention, Cross Government Plan (Public Health England, 2019)
- Five Year Forward View for Mental Health – One year on (NHS England, 2017)
- Preventing Suicide in England: Fourth Progress Report of the Cross-Government Outcomes Strategy to Save Lives (Public Health England, 2019)
- Suicide prevention: A guide for local authorities (Local Government Association, 2014)
- Local Suicide Prevention Resources: Case Studies & Information Sheets (National Suicide Prevention Alliance in association with Public Health England, 2017)
- Local Suicide Prevention Planning in England (Samaritans and University of Exeter, 2019)
- Public Health England advice for local suicide prevention planning
- Local suicide prevention planning, A practice resource, Public Health England, 2020
- January 2019 the national suicide prevention strategy refresh (Fourth Annual Progress Report
- Suicide prevention action plans NICE NG105
- Cross-Government Suicide Prevention Workplan

- Overview | Preventing suicide in community and custodial settings | Guidance | NICE (2018)
- History | Suicide prevention | Quality standards | NICE
- Kirklees suicide and self-harm prevention action plan 2020-2023
- file (bristol.gov.uk)
- LGBT Action Plan 2018: Improving the lives of Lesbian, Gay, Bisexual and Transgender people - GOV.UK (www.gov.uk)
- Queer Futures
- 0521_GW_UoN_collaboration_Autism_Suicide_risk_report_v5_FINAL.pdf - Google Drive
- One in 100 deaths is by suicide (who.int)
- Suicide (who.int)
- Recent trends in suicide: death occurrences in England and Wales between 2001 and 2018 - Office for National Statistics (ons.gov.uk)
- (Children and young people who die by suicide: childhood-related antecedents, gender differences and service contact | BJPsych Open | Cambridge Core)
- Children and young people who die by suicide: childhood-related antecedents, gender differences and service contact | BJPsych Open | Cambridge Core
- Prevalence of non-suicidal self-harm and service contact in England, 2000-14: repeated cross-sectional surveys of the general population - PubMed (nih.gov)
- Estimating suicide among higher education students, England and Wales: Experimental Statistics - Office for National Statistics
- How does living in a more deprived area influence rates of suicide? | National Statistical (ons.gov.uk)
- NCISH | Suicide by middle-aged men (manchester.ac.uk)
- UK Prison Population Statistics - House of Commons Library (parliament.uk)
- | Self-harm: assessment, management and preventing recurrence | Guidance | NICE
- Suicide following presentation to hospital for non-fatal self-harm in the Multicentre Study of Self-harm: a long-term follow-up study — Nuffield Department of Primary Care Health Sciences, University of Oxford
- Suicide prevention: third annual report - GOV.UK (www.gov.uk)
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- The association between mental disorders and suicide: A systematic review and meta-analysis of record linkage studies - ScienceDirect
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- NCISH | Annual report 2023: UK patient and general population data 2010-2020 (manchester.ac.uk)
- Neurodiversity | Local Government Association
- Access to Work: get support if you have a disability or health condition: What Access to Work is GOV.UK
- Medical emergencies in eating disorders (MEED): Guidance on recognition and management (CR233) (rcpsych.ac.uk)
- Suicides in male prisoners in England and Wales, 1978–2003 - ScienceDirect
- Autism and autistic traits in those who died by suicide in England | The British Journal of Psychiatry | Cambridge Core
- Attention-deficit/hyperactivity disorder and suicide: A systematic review - PMC (nih.gov)
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Appendix 2 - Sussex ICS Suicide Prevention Programme (2019-2023

What has been achieved:

Sussex ICS received £1.5m over three years from, beginning in March 2019, to develop, implement and run a three-year suicide prevention programme. The funding was part of the NHS England/Innovation £25m national transformation funding for suicide prevention. Sussex ICS received £623k per annum for the first 2 years and £337,692 in the final year of the programme.

The national programme was supported by the Royal College of Psychiatrists and the National Confidential Enquiry into Suicide and Safety in Mental Health (NCISH) led by Professor Louis Appleby. In receiving the funding local areas were encouraged to be innovative in their thinking and work in partnership. This stimulated the development of a range of collaborative programmes, overseen by a multi-agency working group, chaired by the East Sussex Director of Public Health.

Sussex ICS received further funding of £120k p.a. for 4 years, starting in April 2020, to support the development of a pan-Sussex suicide bereavement service. Bereavement support is the one key initiative that the NHS long term plan has determined should be in place in all ICS areas across England.

RTS and bereavement support
Training – 2 phase approach (1) needs assessment (2) bespoke training
Comms. – continue to use Warning Signs but much more targeted bursts; also focus on promoting bereavement service
GP MH fellowship
SPFT work/serious MH – also SCFT who run IAPTs – much more about reaching out to different orgs. post covid – me to be much more closely aligned to SPFT.

Real Time Surveillance

An analyst has been recruited to 3 days per week post. They are developing the surveillance system and drawing together various data sources which will inform work on clusters and contagion as well as highlighting geographic areas and population groups at risk for more focused interventions. In time the dashboard will include data relating to self-harm and drug related deaths.

Bereavement support

Evidence suggests that timely bereavement support, appropriate to the particular nature of suicide, plays a key part in suicide prevention activity.

Providing support for people bereaved by suicide is a key objective of the national suicide prevention strategy for England[ciii]. Through the Long-Term Plan (LTP), NHSE/I committed to expanding funding for post-vention bereavement services to all areas of the country. Sussex received 4 years of recurrent funding, totalling £480K and is just coming to the end of the second year of funding.

A condition of the funding is that we have a centralised service. The model configured in Sussex relies on a single point of access (SPOA) triaging calls to one of three bereavement support service, for adults based in the local authority areas and a pan-Sussex service commissioned for children and young people up to the age of 25.

The model is working well however a recently completed evaluation of the service highlighted areas that needed developing further and these will be the focus for the service in the coming year.

Training

Equipping our workforces with knowledge of suicide and self-harm prevention is helpful. Particularly amongst the emergency services who often feel ill prepared when they are faced with people with mental health and suicidal issues. The approach up to now has been very piecemeal and is generally reliant on 'off the shelf' training that is not always fit for purpose. A more focused, bespoke approach to training for each workforce, particularly the emergency services is proposed. I have developed bespoke training for SSOS & SOBS on autism & suicide, as well as for Beachy Head Chaplaincy. Also developed and trained urgent care teams for SPFT on autism. All this training was well-received. This should be rolled out more widely.

A pan-Sussex service brings consistency of training, economies of scale and fits in well with the organisational structures of our blue light services such as the ambulance service (SECAMB) and the police (Sussex Police) which are configured at Sussex level rather than by local authorities.

It is envisaged that this work takes place in two stages. The first stage is to carry out a needs assessment to understand the scale of work. The second stage is to develop and implement a plan for identifying key workforces and developing bespoke training across Sussex. One approach could be to procure an experienced training partner to support this work.

Communications

Communications support is needed to increase local knowledge and awareness to the wide range of national and local resources that are available. Alongside this support is needed to ensure local campaigns are coordinated and funding isn't wasted duplicating campaigns that already exist.

The locally developed 'Warning Signs' campaign has been a significant success in reaching out to middle aged men, and those concerned about middle aged men in distress. However much more could be done to promote this campaign and use it in a more targeted way to respond to local concerns.

There is an urgent need for there to be a more co-ordinated communications approach to ensure all those that need them are made aware of the resources available, to ensure consistency of messaging and maximise impact. A pan-Sussex approach also ensures value for money whilst avoiding duplication.

Primary care work

Most people who die by suicide have seen their GP in the previous year. Although this may provide an opportunity for prevention, identifying patients who are at particular risk is difficult and scope to intervene meaningfully is limited within a typical consultation.[civ]

As part of the NHSE/I transformation programme, GP Mental Health fellowships were introduced and currently 3 practising GPs are part of this fellowship attending a series of masterclasses and studying for a PG certificate in healthcare leadership at Canterbury Christ Church University. They will then use this knowledge to identify areas where they can support GP practices and PCNs with increasing their knowledge and response to those at risk of suicide. The GPs already report far greater awareness of the causes of suicide and self-harm and that this has enhanced their current practice.

Debriefing sessions in practices where a patient suicide has taken place should also be carried out as the norm. The effect of a patient suicide on the mental health of those practitioners involved in the care of the patient can be devastating. Debriefing sessions in practices where a patient suicide has taken place, allowing primary care staff the opportunity to talk through the events should be carried out as the norm. Currently this only takes place in practices in Brighton and Hove.

Developing future cohorts of the fellowship and ensuring consistency of debriefing sessions are more efficiently organised at a pan-Sussex level, freeing up staff time and reducing running costs.

Coastal cliffs work

Parts of the southern side of the Sussex geography in East Sussex and Brighton & Hove have high chalk cliffs. In East Sussex a notorious site of public suicide attracts people from all over the country and abroad and is sadly the most frequented public place of suicide in the country. Much work has already taken place over the years to understand the reasons people in distress are drawn to the cliffs and to develop solutions to make it less accessible as a place of suicide.

At a local level people from all three local authorities travel to the cliffs at East Sussex to take their lives but arguably this work needs more traction at a national level, given the significant numbers who travel from outside Sussex who take their lives at the cliffs.

It is imperative that this work continues to maintain a high profile. It should also be recognised that, whilst not as notorious as the East Sussex cliffs, there are cliffs at Brighton and Hove and for these reasons coastal suicide needs to be part of a Sussex wide strategy. It is proposed that the format of meetings that specifically look at coastal suicide, start by focusing on what is already working well at place and moving on to discuss which areas of work need more impact to achieve their aims by becoming a pan-Sussex strategic objective.

Toolkit for Schools in the Event of an Unexpected Death

Toolkit launched in B&H and being adapted for East and West Sussex

- £40k allocated for training for school staff across Sussex on use of toolkit and general suicide prevention training.
- £10k allocated for training of youth workers in B&H as above.

Grassroots commissioned to provide training for approx. 570 staff across Primary, Secondary, SEND and College staff across Sussex.

Self harm and learning network

10 workshops developed for parents, teachers and carers to help with understanding what self-harm is, how to spot the signs and provide support and signposting.

A one-day on-line conference in November was extremely well attended.

Workshops were delivered by the Self-Harm Learning Networks in West Sussex, East Sussex, Brighton and Hove, and by the Allsorts Youth Project (a project supporting LGBTQIA+ youth in Brighton and Hove). Workshops were delivered online and were specifically aimed at teaching staff, and parents and carers.

Warning Signs campaign www.preventingsuicideinsussex.org

The purpose of the campaign is:

- To increase awareness amongst men (and their influencers) of where they might access help if they are finding it difficult to cope with their stress/depression.
- To improve recognition of suicide risk and of how to help, among the influencers in men's lives.
- Consequently, to help contribute towards reducing the stigma associated with help-seeking in men.

The website has received over 24,450 visits since its inception.

Sussex A&E Compassionate care call

This involves a follow-up by compassionate care call, after assessment after an episode of self-harm or suicidal distress in A&E.

Innovation Fund

Small grant fund for voluntary sector organisations across Sussex.

Appendix 3- Risk and Protective Factors for Suicide

Risk Factors

Individual Risk Factors

Previous suicide attempt, depression, other mental illnesses, serious illness e.g., chronic pain, criminal/legal problems, job/financial problems or loss and debt, substance use, Adverse Childhood Experiences (ACEs), violence victimization and/or perpetration, gambling

Relationship Risk Factors

Bullying, domestic abuse, bereavement, relationship breakdown, social isolation and loneliness

Community Risk Factors

Lack of community cohesion, community violence, discrimination, lack of access to healthcare including crisis care

Societal Risk Factors

Stigma associated with help-seeking and mental illness, unsafe media portrayals of suicide, online harms, easy access to lethal means of suicide among people at risk.

Protective Factors

Individual Protective Factors:

- effective coping and problem-solving skills,
- reasons for living (for example, family, friends, pets, etc.),
- strong sense of cultural identity,
- educated and equipped with knowledge and skills for healthy and safe usage of online platforms,
- high-quality signposting and support are prevalent across a range of platforms,
- care provided is person-centred and considers the mental health, physical health, and social needs of those in suicidal crisis,

Relationship Protective Factors:

- support from partners, friends, and family,
- feeling connected to others,
- compassionate, effective and timely support for people bereaved by suicide is essential,
- safe spaces for people to speak up and seek support,
- employers

Community Protective Factors:

- feeling connected to school, community, and other social institutions,
- availability of consistent and high quality physical and mental healthcare,
- support both for substance misuse but also for any mental health or self-harm concerns, with a ‘no-wrong-door’ policy that makes every contact with services count,
- support programmes for people facing difficulties over jobs and benefits,
- action to support people facing financial difficulty,
- tackle the link between suicide and alcohol or drug use, and especially alcohol and drug misuse and dependency,
- take action to support people who feel lonely,
- encourage the voluntary sector and online platforms to continue to ensure that appropriate online signposting and resources reach the right people.

Societal Protective Factors:

- suicide prevention is everyone’s business,
- cultural, religious, or moral objections to suicide,
- reduced access to lethal means of suicide among people at risk,

- first responders and people working on the frontline feel equipped to respond appropriately to deaths by potential suicide, no matter the method used, and have the skills necessary to adapt to the situation they find themselves in,
- encourage those with a role in the planning system to consider the risks of suicide associated with buildings and public spaces and to consult the practice resource Preventing suicides in public places when creating local design policies,
- reducing references to, and limiting awareness of, emerging methods,
- reducing excessive alcohol consumption at a population level and instances of acute intoxication,
- engagement with people with personal experience of substance misuse should inform the development of appropriate treatment practices.
- build a more connected society where everyone is able to build meaningful relationships,
- tackling domestic abuse and identifying victims, including children who witness abuse.
- every individual across the country has access to training and support that gives them the confidence and skills to save lives.

Crisis Care - Protective Factors:

- timely and effective crisis support is available to those who need it,
- people are able to access crisis support in the most appropriate environment for them, when they need it, whether that is through statutory health, VCSE or social care services.
- people can access support in the way that feels most suitable for them,
- information-sharing processes are implemented and strengthened. This includes sharing information about suicide risk with families and carers, pathways between services and sectors are stronger, and uphold a person-centred, joined-up approach to crisis prevention and response, including through timely follow-up and aftercare processes,
- there should be appropriate support and processes in place for responding to a suicidal crisis, including following appropriate risk management, discharge and aftercare processes.

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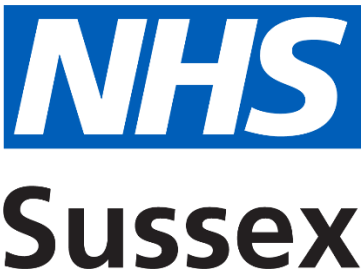
West Sussex Suicide Prevention Framework and Action Plan

2023-2027

With thanks to the following organisations who have worked with us to develop and deliver this framework and action plan.



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1. Introduction

Suicide is used in this strategy to mean a deliberate act that intentionally ends one's life. The World Health Organisation (WHO) highlights suicide as a major public health risk, accounting for one in 100 of all deaths globally[1]. Every suicide is a tragedy that affects families and communities and has long-lasting effects on the people left behind.

Suicide is a serious public health problem; however, suicides can be prevented with timely, evidence-based interventions. For an effective response, local, comprehensive multisectoral suicide prevention strategies are needed[2].

With 5,275 people sadly taking their life in England in 2022[3], it is of the utmost importance that we do all we can to reduce this number as far as possible in West Sussex. However, it is equally important, that when someone ends their life by suicide, their family, friends, and broader community who have been bereaved, have the support they need to manage their loss. Bereavement itself is a risk-factor for suicide[4].

The COVID-19 pandemic has brought new challenges and change across the world, nationally, and locally, to each of our lives, with disruptions to the way we live, work and how we interact with others. Furthermore, cost-of-living pressures in the UK will likely continue to have an impact on people's mental health and wellbeing.

On 11 September 2023 the government published its new national strategy Suicide Prevention in England: 5-year cross-sector strategy[5]. This strategy is the update to the previous strategy published in 2012 and there have been five government progress reports published since then, with the most recent report issued in March 2021. The new national strategy reflects the latest evidence and national priorities for preventing suicides, outlines eight action areas and covers the following priority groups and risk factors at population level.

Priority groups	**Risk factors at a population level**
• Children and young people • Middle-aged men • People who have self-harmed • People in contact with mental health services • People in contact with the justice system • Autistic people • Pregnant women and new mothers	• Physical illness • Financial difficulty and economic adversity • Gambling • Alcohol and drug misuse • Social isolation and loneliness • Domestic abuse

[1] One in 100 deaths is by suicide (who.int)
[2] One in 100 deaths is by suicide (who.int)
[3] Quarterly suicide death registrations in England - Office for National Statistics
[4] Bereavement by suicide as a risk factor for suicide attempt (national library of medicine)
[5] Suicide prevention strategy for England: 2023 to 2028 GOV.UK

Work commenced in September 2022 to develop this new West Sussex Suicide Prevention Framework and Action Plan 2023-2027, which updates the West Sussex Suicide Prevention Strategy 2017-2020. The purpose of the document is to provide a framework and plan for action for multi-agency partners in West Sussex to work together to reduce risk of suicides. It covers all ages, and dovetails with the Sussex Suicide Prevention Strategy (this includes the local authority geographical areas of Brighton and Hove, East Sussex, and West Sussex) and Action Plan (2024-2027), to ensure an aligned approach locally and Sussex-wide. Both documents follow national guidance and strategy and will adapt and absorb the latest evidence and information as and when published. Two main areas of focus have informed their development:

1. A review of the latest evidence, including academic research, government policy, public health guidance, and national and local data.
2. An engagement exercise with key stakeholders from the Sussex Suicide Prevention Partnership in summer 2022, where views were sought on seven proposed action areas for the Sussex Suicide Prevention Strategy and Action Plan (2024-2027). Groups and individuals consulted include community and voluntary sector groups, NHS, and local authorities.

Our West Sussex framework and action plan recommends bringing together knowledge about people at higher risk of suicide and applying evidence of effective interventions to reduce the risk of suicide across West Sussex. It incorporates evidence of existing priorities and looks at areas where there is increasing evidence, rising concern and priorities covered within the national suicide prevention strategy for England: 2023 – 2028.

2. Our Vision

The aim of this framework and action plan is to reduce the risk of suicide in West Sussex.

In line with the national strategy, Suicide prevention in England: 5-year cross-sector strategy[6], and associated Suicide prevention strategy: action plan[7] and aligned with the Sussex Suicide prevention Strategy and Action Plan the aims are to:

- reduce the suicide rate over the next five years – with initial reductions observed within half this time or sooner.
- improve support for people who have self-harmed.
- improve support for people bereaved by suicide.

West Sussex is a place where:

- We are committed to reducing the risk factors and increasing the protective factors for suicide across the life course.

[6] Suicide prevention in England: 5-year cross-sector strategy - GOV.UK
[7] Suicide prevention strategy: action plan - GOV.UK

- We build individual and community resilience to improve lives and prevent people falling into crisis by tackling the risk factors for suicide.
- We recognise that suicides can be prevented, and that people do not inevitably end up considering suicide as a solution to the difficulties they face.
- We create an environment where anyone who needs help knows where to get it and is empowered to access that help.

2.1 Our Approach

Our approach focuses on the below nine key areas, as these were developed prior to the publication of the national strategy (2023 – 2028) they are mapped against the new national strategy action areas.

1) System leadership and governance

   National Strategy action area 8: "Making Suicide everybody's business"

2) Communications

   National strategy action area 4: "Promote online safety and responsible media content, improve support and signposting and helpful messaging"

3) Reduce the risk of suicide and improve the mental health of key high-risk groups

   National strategy action areas 3 and 5: "address common risk factors linked to suicide at a population level" and "provide effective crisis support"

4) Tailor approaches to mental health in risk groups

   National strategy action areas 2 and 5: "provide tailored, targeted support to priority groups" and "provide effective crisis support"

5) Reduce access to means of suicide

   National strategy action area 6: "reduce access to means and methods"

6) Provide bereavement support to those bereaved and affected by a suicide

   National strategy action area 7: "provide effective bereavement support to those affected by suicide"

7) Use of data to support planning, response and learning

   National strategy action area 1: "improve data and evidence"

8) Training

   National strategy action area 8: "making suicide everybody's business"

9) Reduce the risk of self-harm

   National strategy action area 2: "provide tailored support to priority groups"

The West Sussex Suicide Prevention Framework action plan for year two (April 2024 – March 2025) will reflect the Sussex Suicide Prevention Strategy 2024 – 2027 and national strategy (2023 – 2028) action areas.

3. Governance and Accountability

The need to develop local plans that engage a wide network of stakeholders was established in the government's national strategy for England, 'Preventing suicide in England[8]' released in 2012. Councils were given the responsibility for leading the development of local suicide action plans through their work with health and wellbeing boards.

The new national strategy highlights the importance of cross-sector working and joint action, including at a local level through integrated care partnerships, integrated care boards (ICBs), local authorities and local suicide prevention organisations.

This is a partnership framework and action plan monitored and overseen by the West Sussex Suicide Prevention Steering Group (multi-agency) which reports into the West Sussex Mental Health Oversight Board and the Pan-Sussex Suicide Prevention Steering Group. In addition:

- Updates will be shared, as required, with the West Sussex Health and Wellbeing Board.
- Specific actions for children and young people are overseen and implemented by the Children and Young People Suicide Prevention sub-group of the West Sussex Suicide Prevention Steering Group, linking with the Children and Young People Emotional Wellbeing and Mental Health sub-group, which reports to the West Sussex Children's First Board. Updates as required, are shared with West Sussex Safeguarding Children's Partnership, NHS Sussex Children's Board, and the West Sussex Health and Wellbeing Board.

Appendix 1 presents this information in diagrammatic form.

Governance and accountability structures will be regularly reviewed and updated where required.

Whilst public health teams in local authorities provide leadership, multi-agency partnerships have responsibility for overseeing and delivering much of the suicide prevention activity, addressing as they do many of the known risk factors, such as alcohol and drug misuse[9].

Councils (including district, borough, and parish councils) span efforts to address wider determinants of health such as employment and housing. NHS Integrated Care Boards hold the responsibility for all health and care services and specific to suicide prevention, bereavement support. In addition, there are important opportunities to reach local people who are not in contact with health services through online initiatives and through working with the voluntary and community sector.

[8] Preventing suicide in England - A cross-government outcomes strategy to save lives (opens a pdf)
[9] Public Health England Local Suicide Prevention Planning A practice resource (opens in a pdf)

NHS trusts provide over half of all NHS hospital, mental health and ambulance services. Consequently, they have a crucial role to play in suicide prevention including front line mental health services.

4. Risk factors and groups or individuals who have increased risk

4.1 Socio-economic deprivation

Suicide rates are higher among men and women living in the most deprived areas of England. Middle-aged men (40-59 years) have higher suicide rates in the most deprived areas – up to 36.6 per 100,000 compared to 13.5 per 100,000 in the least deprived areas. The effect of social deprivation on risk of suicide impacts more on working-age people, but not on those aged under 20 or those aged over 65 (it is likely that risk factors other than deprivation are more significant at these ages)[10].

West Sussex is overall a relatively affluent area. In terms of relative deprivation, compared to other areas, it is one of the least deprived areas in the country, ranking 129 out of 151 upper tier authorities (1 being most deprived, 151 being least deprived). In relation to neighbouring authorities, West Sussex is less deprived than East Sussex (ranked 93) and Brighton and Hove (ranked 87). However, there are areas of deprivation within the county, with Crawley ranking as the most deprived lower-tier local authority area in West Sussex, followed by Arun, Adur, and Worthing, and coastal areas of the county, including Bognor Regis and Littlehampton in Arun district[11]. Social mobility is low in some areas of the county, notably Crawley.

4.2 Men

Men aged 35 – 49, particularly from lower socio-economic groups, are most at risk of taking their own life[12]. For men aged 40 to 50 years, the highest rates of suicide were in disabled people, those who have never worked or are in long-term unemployment or are single (never been married or in a civil partnership)[13]. Personality traits, challenges of mid-life, relationship breakdown, bereavement, lack of health-seeking behaviour and socio-economic factors – such as unemployment and addictions including alcoholism and gambling – are some of the various reasons men might take their own lives. For older men, loneliness, long-term ill-health, caring for a partner and financial worries are contributory factors.

4.3 Occupation and unemployment

Analysis of 2011[14] Census data demonstrates different risk profiles amongst different occupations for example, men working in the lowest-skilled occupations had a 44% higher risk of suicide than the male national average. The risk among

[10] How does living in a more deprived area influence rates of suicide (ONS.GOV.UK)
[11] West Sussex Joint Strategic Needs Assessment briefing indices of deprivation 2019 (opens a pdf)
[12] Suicide by middle-ages men University of Manchester (opens a pdf in browser)
[13] Sociodemographic inequalities in suicides in England and Wales - Office for National Statistics (ONS.GOV.UK)
[14] 2011 ONS Census data is used in this plan where 2021 ONS census data is not yet published.

men in skilled trades was 35% higher than the average. Individuals working in roles as managers, directors, and senior officials – the highest paid occupation group – had the lowest risk of suicide. Among corporate managers and directors, the risk of suicide was more than 70% lower for both sexes[15].

The risk of suicide was elevated for those in culture, media, and sport occupations for males (20% higher than the male average) and females (69% higher than female average). There is also higher risk in some health professional groups.

Unemployment is a key risk factor for all, particularly men between 40 and 60, along with other causes including unmanageable debt, and social isolation[16]. In the 2008 – 2010 recession there was a 1.4% rise in suicide rates for every 10% increase in unemployment in men[17].

In West Sussex 92,900 people aged 16-64 years are estimated to be economically inactive (April 2020 to March 2021). Of these, over 68,500 are not seeking a job; with 16,000 people with long term sickness, 14,900 looking after the home or family, and 15,700 retired.

The employment rate gap is the difference in the percentage of people who are part of a vulnerable group who are employed, compared to the percentage of all respondents in the Labour Force Survey classed as employed (aged 16-64). In 2020/21 the employment rate gap for people with learning disability was 77.9% in West Sussex compared to the overall rate across England of 70.6%. In 2020/21, for people with a long-term health condition, the employment rate gap in West Sussex was 7.1%, worse than England rate of 9.9%. In West Sussex the employment rate gap for people in contact with secondary mental health services was 67.3% in 2020/21, this was similar to the England rate of 66.1%.

4.4 Economic adversity, debt, gambling and the cost of living

A national study of 1,516 UK male suicides in 2021 found that 30% of these men had experienced financial problems. These include debt due to gambling; concerns about money owed on credit cards, loans, or mortgage repayments; worries that benefit payments would be reduced or stopped; and threats of court proceedings or bailiff notices. In 2021, 2% of UK male suicides reported gambling problems with or without associated financial problems[18].

A national survey of counsellors and psychotherapists in 2022 found that 66% of respondents' clients' mental health was declining due to the cost-of-living pressures, including increasing insomnia because of anxiety. The survey respondents reported that their clients were cutting back on exercise through

[15] Suicide by occupation, England - Office for National Statistics (ons.gov.uk)
[16] How does living in a more deprived area influence rates of suicide? September 2020 - a blog by Ben-Windsor-Shellard – ONS.GOV.UK
[17] Suicides associated with the 2008-10 economic recession in England: time trend analysis, The BMJ
[18] Suicide by middle-aged men 2021 National Confidential Inquiry into Suicide and Safety in Mental Health (opens a pdf)

cancelling sports clubs and gym membership, and some are stopping therapy due to cost[19].

4.5 Family and friend carers

Male and female carers, who look after people who are sick, elderly and disabled, have a higher-than-average risk of suicide[20]. There are an estimated 90,405 unpaid carers of all ages in West Sussex, representing 10.4% of the total population (similar to England). Around 9 million people in the UK provide unpaid care to family or other relatives.

4.6 Children and young people

Concern has grown for children and young people as the numbers of suicides have risen both nationally and locally. Suicide in the under 20s has seen increases for a decade[21]. For the year 2019-2020, there were 108 deaths in children and young people in England that were assessed as likely to be due to suicide. Whilst the number of suicides in children and young people remains relatively small in Sussex, the numbers in younger age groups are increasing, matching national trends.

A UK-wide study[22] of suicide deaths in young people aged 10-19 years, reported antecedents such as witnessing domestic abuse, bullying, self-harm, bereavement (including by suicide) and academic pressures. Nationally overall, 60% of those young people who died by suicide, had been in contact with specialist children's services.

Nationally, the change in rates of suicide amongst young people is mirrored by increasing rates of hospital admissions for self-harm in the same age (10 to 24 years), particularly for young females.

[19] British Association of Counsellors and Psychotherapists Cost of Living Survey September 2022
[20] Suicides in England and Wales Statistical bulletins - Office for National Statistics (ons.gov.uk)
[21] Recent trends in suicide: death occurrences in England and Wales between 2001 and 2018 (ons.gov.uk)
[22] Children and young people who die by suicide: childhood-related antecedents, gender differences and service contact - Cambridge Core

What do we know about suicide issues in children and young people?

Below are key findings from suicide by children and young people. National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) (2017)[23]

- 52% of suicides in under 20's reported **previous self-harm**.
- **Events in childhood** impact negatively on health in adulthood (physical and mental health), reducing the impact will help reduce young people and adult suicides.
- **Trauma, including suspected or confirmed cases of abuse,** neglect, and domestic abuse, was seen in more than a quarter (27.1%) of children who died by suicide.
- **Family-related problems**, such as divorce, custody disputes, parental substance use, or a family history of suicide or mental health concerns, were seen in more than a third (39.8%) of children who died by suicide.
- **Bereavement** was a specific issue for young people with 25% of under 20's and 28% of 20–24-year-olds experiencing bereavement.
- **Looked After Children** were a population group accounting for 9% of suicides in under 20's, with specific issues highlighted around housing and mental health.
- 6% of suicides in under 20's occurred in **lesbian, gay, bisexual, and transgender (LGBT) people** of whom one quarter had been **bullied.**
- **Suicide-related internet use** was found in 26% of deaths in under 20s.
- **Students under 20** more often took their lives during April and May linked to academic pressures.
- **Mental health concerns** were identified in a third (31.4%) of the suicide deaths examined, with the most common diagnoses being attention-deficit/hyperactivity disorder (ADHD) or depression.
- **ADHD** is a neurodevelopmental condition along with Autism Spectrum Conditions. Both have a significantly increased risk of suicide ideation, self-harm, attempted suicide, and death by suicide. Co-morbidities such as extreme levels of anxiety, depression and being the victim of severe bullying are common.

Looked after children have an especially increased suicide risk[24], with specific issues highlighted around housing and mental health[25]. In 2021/22 there were 399 Looked After Children in West Sussex, a rate of 49 per 100,000 children.

[23] National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) 2017 (opens a pdf)
[24] National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) 2017 (opens a pdf)
[25] National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) 2017 (opens a pdf)

4.7 LGBTQI+ (Lesbian, Gay, Bisexual, Transgender, Querying (or Queer), Intersex, plus

People from the LGBTQI+ community are increasingly identified as having higher risk of suicide. Nationally 6% of suicides in under 20s occurred in lesbian, gay, bisexual, and transgender (LGBT) people, of whom one quarter had been bullied[26]. Higher prevalence of mental health problems among people who are LGBT may be linked to experience of discrimination, homophobia, or transphobia, bullying, social isolation, or rejection because of sexuality[27].

4.8 Bereavement

Suicide has a broad impact, not only on immediate family and close friends, but also on colleagues and wider society. Those bereaved by suicide have an increased risk of suicide and are more likely to experience poor mental health[28].

4.9 Disability

Nationally, disabled people have higher rates of suicide compared with non-disabled people. This data is from the 2011 Census where disability status was assessed by asking "Are your day-to-day activities limited because of a health problem or disability which has lasted, or is expected to last, at least 12 months?"[29].

4.10 People with pre-existing mental illness

Most suicides are related to significant mental illness, with depression, substance use disorders and psychosis being the most relevant risk factors; anxiety, personality, eating, and trauma-related disorders, as well as organic mental disorders, also contribute[30]. There is an approximate 10-fold increase in the risk of suicide in people under care for mental illness[31].

4.11 Pregnant women and new mothers

In the UK, suicide is the leading cause of direct deaths 6 weeks to a year after the end of pregnancy[32]. In 2020, nationally women were 3 times more likely to die by suicide during or up to 6 weeks after the end of pregnancy compared with 2017 to 2019. Impacts on affected families are devastating and often have lasting effects, particularly on children from a very early stage in their development.

Overall, the level of risk of suicide after pregnancy is not higher than at other times in a woman's life. However, the high risk compared with other causes of maternal death (most of which are rare) and the potential long-term

[26] National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) 2017 (opens a pdf)
[27] Mental health support if you are gay, lesbian, bisexual, lgbtq (NHS.UK)
[28] Suicide by middle-aged men University of Manchester and Bereavement and suicide - bereavement as an antecedent of suicide in children and young people University of Manchester
[29] Sociodemographic inequalities in suicides in England and Wales (ONS.GOV.UK)
[30] Suicide Risk and Mental Disorders Bradvik, L, 2018 National Library of Medicine (Int J Environ Res Public Health)
[31] Preventing suicide in England 2021 - Fifth progress report of the cross-government outcomes strategy to save lives (opens a pdf)
[32] MBRRACE-UK_Maternal_Surveillance_Report_2023.pdf (ox.ac.uk)

consequences on children's development mean we must take action to prevent suicides in this group. The increasing numbers of teenage maternal suicides, in particular care leavers, in recent years is a significant concern and particular targeted support is needed for this age group.

4.12 Self-harm

Self-harm, the deliberate action of causing physical harm to oneself, is a clear sign of emotional distress. The relationship between self-harm and suicide is complex. In many cases self-harm is used as a non-fatal way of coping with feelings and stressors, particularly in young people. Nevertheless, self-harm is the single biggest single indicator of suicide risk[33].

Whilst suicide is more common in men, nationally self-harm is more common in women[34]. Approximately 50% of people nationally who die by suicide have previously self-harmed[3536]. In a large study based on the UK national database of presentations to hospital for self-harm, 45% of presentations to hospital were from the most deprived areas.

Rates of self-harm (all ages) in each local authority area in Sussex in 2021/22 (as measured using hospital admissions for serious self-harm) are higher than the England average as shown in Table 1 below.

Table 1: Rates of self-harm (all ages) for Brighton and Hove, East Sussex, and West Sussex local authority areas 2021/22

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	93,895	163.9	162.8	164.9
Sussex	–	-	-	-	-
Brighton and Hove	–	885	284.1	265.3	303.8
East Sussex	–	1,240	250.3	236.4	264.8
West Sussex	–	1,575	189.2	179.9	198.9

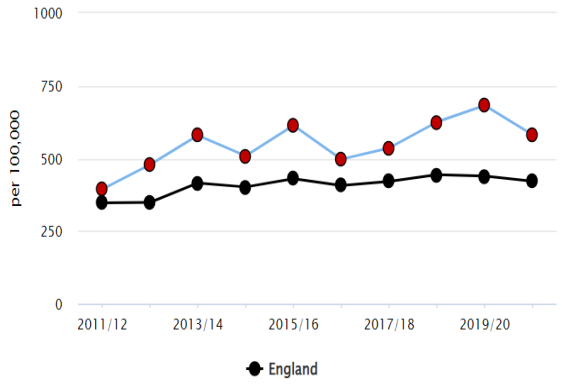
Source: Hospital Episode Statistics (HES), NHS Digital, for the respective financial year, England. Hospital Episode Statistics (HES) Copyright © 2023, Reused with the permission of NHS Digital. All rights reserved. Local Authority estimates of resident population, Office for National Statistics (ONS) Unrounded mid year population estimates produced by ONS and supplied to Office for Health Improvement and Disparities Local Authority estimates of resident population, Office for National Statistics (ONS) Unrounded mid-year population estimates produced by ONS and supplied to the Public Health England. Analysis uses the single year of age grouped into quinary age bands, by sex.

The National Suicide Prevention Strategy 2012, updates, and NHS data[37] show an increase in need for mental health services, particularly for young people admitted to hospital for self-harm.

Chart 1 demonstrates that while West Sussex emergency hospital admissions for intentional self-harm (18-24 years old) are consistently above England's average, in line with national trends the numbers of young people admitted to hospital has seen an overall increase since 2017/18 to 2020/21 in this population group. To note, the below data includes repeat admissions and there are multi-agency programmes in place in West Sussex to reduce risk of self-harm for young people.

[33] Self-harm - assessment, management and preventing recurrence – guidance by NICE – September 2022
[34] Suicide and Self Harm, Knipe, D May 2022, The Lancet
[35] Children and young people who die by suicide: childhood-related antecedents, gender differences and service contact - BJPsych Open, Cambridge Core
[36] Suicide prevention: third annual report - GOV.UK
[37] NHS England - NHS helps record numbers of young people with their mental health as students return to universities

Chart 1: West Sussex Self-Harm Hospital Admissions for 18 – 24 years old 2011/12 – 2020/21.



Recent trend: ↑ Increasing & getting worse

Period		West Sussex Count	Value	95% Lower CI	95% Upper CI	South East	England
2011/12		505	394.4	360.6	430.6	350.9	347.4
2012/13		616	478.8	441.5	518.4	350.6	348.9
2013/14		748	579.5	538.5	622.9	422.7	415.8
2014/15		665	509.1	471.0	549.5	415.0	401.9
2015/16		798	613.7	571.6	658.0	469.3	430.5
2016/17		637	497.4	459.3	537.8	449.0	407.1
2017/18		685	535.9	496.3	577.9	467.6	421.2
2018/19		795	625.4	582.5	670.7	470.2*	444.0
2019/20		860	682.6	637.4	730.2	508.9	439.2
2020/21		745	581.8	540.4	625.5	505.6	421.9

Source for the above chart: Fingertips.phe.org.uk

4.13 Domestic abuse

There is a clear association between intimate partner abuse and attempted suicide, with attempted suicide nearly three times higher in those who have experienced domestic abuse[38]. Suicidality is high in both those who perpetuate intimate partner abuse and those who are victims / survivors of domestic abuse[39]. A national study found a strong graded relationship between exposure to abuse or household dysfunction during childhood and multiple risk factors for several of the leading causes of death in adults[40].

4.14 Substance misuse

People who abuse alcohol and drugs experience greater than average economic disadvantage, debt and unemployment, social isolation, and other complex needs, and have higher rates of mortality and morbidity[41].

Collectively, substance use disorders confer a risk of suicide that is 10–14 times greater than that of the general population; deaths related to substance use are highest among people with alcohol use disorders followed by persons who abuse opiates[42].

People who are dependent on alcohol are approximately 2.5 times more likely to die by suicide than the general population[43]. In England, nearly half (45%) of all patients under the care of mental health services who die by suicide have a history of alcohol misuse, accounting for 545 deaths per year on average[44].

[38] The Conditional Indirect Effects of Suicide Attempt History and Psychiatric Symptoms on the Association Between Intimate Partner Violence and Suicide Ideation C Wolford-Clevenger 2017
[39] The perpetrators of domestic violence - Romans - 2000 - Medical Journal of Australia
[40] Adult substance misuse treatment statistics 2020 to 2021 GOV.UK
[41] From harm to hope: A 10-year drugs plan to cut crime and save lives - GOV.UK
[42] A Closer Look at Substance Use and Suicide | American Journal of Psychiatry Residents' Journal
[43] Alcohol-Related Risk of Suicidal Ideation, Suicide Attempt, and Completed Suicide: A Meta-Analysis, PLOS ONE
[44] National Confidential Inquiry into Suicide and Safety in Mental Health University of Manchester

4.15 Neurodivergence

Neurodivergence is the term used for people whose brains function differently in one or more ways than is considered standard or typical[45]. Every person's brain is unique to them and they will have unique skills, abilities and needs. Someone who is neurodivergent behaves, thinks and learns differently to those who are neurotypical. The term neurodivergence includes Autism and attention-deficit/hyperactivity disorder (ADHD) conditions.

There is emerging evidence that Autism and ADHD are significant indicators for suicide risk. National research looking at 372 coroners' inquest records, from 1 January 2014 to 31 December 2017 in two regions of England, showed that 10% of those who died by suicide had evidence of elevated autistic traits, indicating likely undiagnosed autism[46]. This is 11 times higher than the rate of autism in the UK.

Neurodivergent individuals can be exposed to certain social and emotional challenges and may struggle with social interactions, communication, and emotional regulation, which can also lead to feelings of isolation, loneliness, and despair. The increased risk may also relate to social stigma, discrimination, bullying, and marginalisation in society.

People with neurodivergent disorders may also face additional barriers when trying to access mental health support and resources, including the lack of neuro-affirmative practices and challenges in understanding the needs of neurodivergent people.

Neurodivergent people may also face barriers in gaining support to access employment or to remain in employment. Such support is available through Access to Work and specifically specialist work-based coaching[47].

4.16 Homelessness

Suicide is the second most common cause of death among people who are homeless or rough sleepers in England and Wales, accounting for 13% of deaths among homeless people or rough sleepers in 2018[48].

People who are homeless have a higher proportion of mental disorders than people with stable accommodation, particularly psychotic illness, personality disorders and substance misuse[49]. Nationally 45% of people experiencing homelessness have been diagnosed with a mental health issue, compared to an estimated rate of 25% in the general population[50]. This rises to 8 out of 10 people who are sleeping rough.

4.17 Military veterans

There are comparatively few international studies investigating suicide in military veterans but a recent study in the UK investigated the rate, timing, and risk

[45] What does it mean to be neurodivergent? (verywellmind.com)
[46] Autism and autistic traits in those who died by suicide in England, The British Journal of Psychiatry, Cambridge Core
[47] Access to Work: get support if you have a disability or health condition (GOV.UK)
[48] Deaths of homeless people in England and Wales - Office for National Statistics (ONS.GOV.UK)
[49] The Prevalence of Mental Disorders among the Homeless in Western Countries: Systematic Review and Meta-Regression Analysis - PMC (nih.gov)
[50] 2021 Mental Health Statistics: prevalence services and funding in England

factors for suicide in personnel who left the UK Armed Forces (UKAF) over a 22-year period (1996 to 2018)[51]. This found that overall suicide risk in veterans was comparable to the general population but there were important differences according to age, with higher risk in young men and women. Several factors increased the risk of suicide, but deployment was associated with reduced risk.

4.18 People in contact with the criminal justice system

People in contact with the justice system have higher rates of suicide and self-harm behaviour than the general population and there are higher rates of suicide in people on probation compared with the general population[52].

5. Data

5.1 National profile

In 2022, there were 5,275 recorded suicides in England, equivalent to an age-standardised mortality rate of 10.6 deaths per 100,000 people, this rate was similar to 2021 but statistically significantly higher than 2020; however, 2020 saw a decrease in suicide rates because of the impact of the coronavirus (COVID-19) pandemic on the coroner's inquests, and a decrease in male suicides at the start of the pandemic[53].

Based on 2019 data, numbers of suicides began to increase in England in 2018, after four years of decline. While the exact reasons for the 2018 increase are unknown and could include changes to the recording of deaths by suicide, the latest data shows that the rise was largely driven by an increase among men- who have continued to be most at risk of dying by suicide[54]. Of the suicides recorded in England in 2021, just under 74% were men, at 15.8 per 100,000 population, compared to 5.5 per 100,000 population for women[55]. In recent years, nationally there have also been increases in the rate of suicide among young adults, with females under 25 reaching the highest rate on record for their age group. Overall, people aged 10 to 24 years, and men aged 45 to 64 years have seen the greatest increases in suicide rates during the period[56]. Data from the National Child Mortality Database shows that Suicide and Deliberate Self Harm remains one of the leading causes of deaths for the reviews of children in England aged 15-17 years[57].

5.2 West Sussex profile

West Sussex has a population of approximately 867,600[58]. Chart 2 below shows that the rate of suicide (all ages) in West Sussex of 11.5 per 100,000 population (75 people per year) exceeds the England average of 10.4 per 100,000 population but is lower than other parts of Sussex (Brighton and Hove rate 14.1

[51] New figures provide latest data on veteran's suicide (GOV.UK)
[52] Health & Justice | Home page (biomedcentral.com)
[53] Quarterly suicide death registrations in England - Office for National Statistics
[54] Suicide prevention in England: fifth progress report – (GOV.UK)
[55] Suicides in England and Wales: 2021 registrations ONS.GOV.UK
[56] Preventing suicide in England: Fifth progress report of the cross-government outcomes strategy to save lives (opens a pdf)
[57] Child death data release 2022 | National Child Mortality Database (ncmd.info)
[58] Joint Strategic Needs Assessment (westsussex.gov.uk)

and East Sussex rate 12.1 per 100,000 population). The rate is measured over a three-year period, 2019 – 2021[59].

Chart 2: Comparison of West Sussex suicide rate with England, the South-East region, and local authorities in the South-East[60]

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	15,447	10.4	10.3	10.6
South East region	–	2,558	10.6	10.2	11.0
Brighton and Hove	–	113	14.1	11.4	16.8
Isle of Wight	–	48	13.8	10.0	18.4
Milton Keynes	–	91	12.9	10.4	15.8
East Sussex	–	179	12.1	10.3	14.0
Reading	–	49	12.0	8.8	16.0
West Berkshire	–	48	11.9	8.7	15.8
Kent	–	479	11.7	10.6	12.7
West Sussex	–	265	11.5	10.1	12.9
Buckinghamshire UA	–	157	11.0	9.3	12.7
Medway	–	76	10.6	8.4	13.3
Surrey	–	316	10.1	9.0	11.2
Oxfordshire	–	181	10.0	8.6	11.5
Portsmouth	–	56	9.9	7.4	13.0
Southampton	–	63	9.5	7.2	12.3
Hampshire	–	321	8.9	8.0	9.9
Slough	–	31	8.7	5.8	12.5
Bracknell Forest	–	28	8.4	5.6	12.1
Windsor and Maidenhead	–	31	8.2	5.5	11.7
Wokingham	–	26	6.0	3.9	8.8

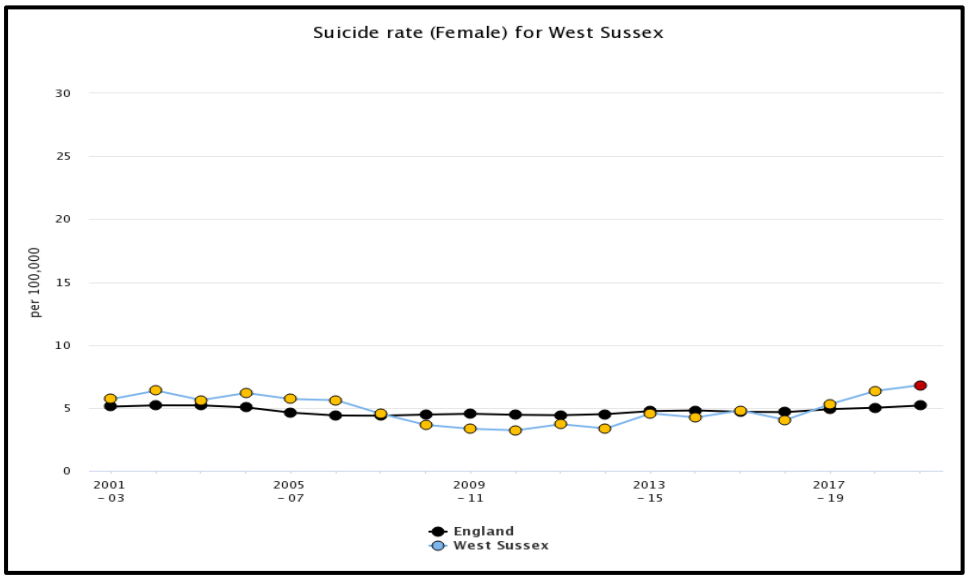
Source: Office for National Statistics

The rates of suicide amongst men and women in West Sussex per 100,000 population, are slightly higher than the England rates per 100,000 population; 16.6 for men, compared with the England rate of 15.9, and 6.8 for women, compared to 5.2 for England.

[59] Local Authority Health Profiles - Data - OHID (phe.org.uk)
[60] Suicide Prevention Profile - OHID (phe.org.uk)

The suicide rate for women in West Sussex has increased since 2017 in comparison to England, as shown by Chart 3 below (where the dot in the chart is yellow, the rate is not significantly different to England, where the dot is red it is significantly worse).

Chart 3: Suicide rate (female) for West Sussex[61]



Since February 2022, real-time surveillance (RTS) data has been available in West Sussex. This is information gathered via police colleagues at the scene of an unexpected death which may be due to suicide. These suspected suicides have not yet gone through the coronial system, but they present important and timely information on local suicides.

The advantage of real time surveillance is it allows us to respond quickly to emerging trends that point to particular risk factors or high-risk groups locally. We can put in place prompt mitigations and the data also allows us to provide timely support to those who have been recently bereaved or affected by suicide.

[61] Public Health profiles, Office for Health Improvement and Disparities

6. Suicide Prevention Framework Action Plan 2023-2027: Year 1 actions[62]

This plan has been developed with multi-agency partners to respond to the data and evidence and incorporates input from the engagement exercise with key stakeholders from the Sussex Suicide Prevention Partnership during summer 2022. As this happened before the national strategy "Suicide Prevention in England: 5-year cross-sector strategy (11 September 2023)[63] was published, the West Sussex action plan has been mapped to the eight action areas of the national strategy. The West Sussex action plan will be updated annually and for year 2 (April 2024 – March 2025) the action plan will be developed in line with the new national strategy and the Sussex Suicide Prevention Strategy action areas. Delivery of the action plan is monitored via the West Sussex Suicide Prevention Steering Group.

Key Action Area	Action	Success measures / Outputs and outcomes
1.System leadership and governance National Strategy action area 8: "Making Suicide everybody's business"	• To publish and disseminate the Suicide Prevention Framework and Action Plan 2023-2027 and update the plan annually and as required – it is a 'living' document, adaptable to changing guidance, national and local strategies • To collaborate with and involve 'Experts by experience' and communities throughout delivery of the action plan	Annual update of framework and action plan Service delivery is co-produced and informed by 'Experts by experience'

[62] PHE_LA_Guidance_25_Nov.pdf (publishing.service.gov.uk)
[63] Suicide prevention strategy for England: 2023 to 2028 - GOV.UK (www.gov.uk)

Key Action Area	Action	Success measures / Outputs and outcomes
2.Communications and engagement National strategy action area 4: "Promote online safety and responsible media content, improve support and signposting and helpful messaging"	• Develop and deliver a communications and engagement plan for improving mental health and prevention of suicide and self-harm • To conduct an evidence review and develop a plan to reduce online harms	Increasing understanding, awareness and uptake of services and support Evidence review report and plan to reduce online harm developed
3. Reduce the risk of suicide in priority groups National strategy action areas 3 and 5: "address common risk factors linked to suicide at a population level" and "provide effective crisis support"	**Adults** • Support for those who have attempted suicide • Strengthen access to support for cost-of-living pressures and financial challenges • Develop a plan for reducing isolation and loneliness for men 35-59 years • Delivery of support for older people focused on tackling social isolation, increasing access to advice and information • Delivery of 10 ways to improve safety and reduce suicide in mental health services framework[64] • To agree work with General Practices and pharmacies • Review evidence and data to understand risks for suicides for women including pregnant women and new mothers and develop recommendations for action	**Adults** Increase in support Reduction in risk of suicide by high-risk group A plan for reducing isolation and loneliness for men 35-59 years Delivery of the 10 ways to improve safety programme Work agreed within General Practices and pharmacies Review conducted and recommendations agreed for support for women including pregnant women and new mothers

[64] A national framework developed by the National Confidential Inquiry into suicide and safety in mental health services University of Manchester (opens a pdf in a browser)

Key Action Area	Action	Success measures / Outputs and outcomes
3. Reduce the risk of suicide in priority groups (cont) National strategy action areas 3 and 5: "address common risk factors linked to suicide at a population level" and "provide effective crisis support"	**Children and Young People (CYP):** • Ongoing delivery of multi-agency mental health triage to reduce risk of self-harm and suicide • Support for CYP transitioning to adults' services and review support for Care Leavers regarding suicide prevention, mental health and housing • Ongoing delivery of Mental Health Support Teams (MHSTs) 2023/24 to cover 50% of state-funded schools in West Sussex (national target coverage) • Adapt the Sussex toolkit for Unexpected Deaths in schools for West Sussex schools, and deliver training to support implementation of the toolkit • LGBTQI+ training for schools	**Children and Young People (CYP):** Reduced risk of self-harm and suicide Support offer for people transitioning from CYP services to adults Mental Health Support Teams (MHSTs) covers 50% of state-funded schools in West Sussex Production and implementation of West Sussex unexpected death toolkit and delivery of training Provision of LGBTQI+ training
4.Tailor approaches to improve mental health in specific groups National strategy action areas 2 and 5: "provide tailored, targeted support to priority groups" and "provide effective crisis support"	• Increase access for support for gambling • Increase support to address the impact of cost-of- living pressures, debt, gambling and financial challenges • Increase access to suicide prevention support for people with multiple needs • Review support for carers through commissioned services • Support for frontline mental health workers through debrief processes and access to support • Data review of suspected suicides and those in contact with the criminal justice system	Improved access to information and support for priority groups Review report of support for carers Report on criminal justice and suicide

Key Action Area	Action	Success measures / Outputs and outcomes
4.1 Victims / survivors, perpetrators of and children exposed to domestic abuse	• Review of Domestic Abuse Services pathways regarding risk of suicide and self-harm • Suicide prevention training for staff (WSCC, NHS and Community and voluntary sector) • Develop a communication briefing for staff working across different services to describe the links between suicidality and domestic abuse	Domestic abuse service pathway review conducted Domestic abuse services in Children's Services are trained on suicide prevention Communications briefing for staff produced
4.2 Co-occurring substance misuse and mental health issues	• Improve system and treatment pathways for people with co-occurring substance misuse and mental health conditions and who experience health inequalities • Development of a joint co-occurring conditions pathway protocol for adults between mental health, substance misuse, and housing and homelessness services, followed by training and evaluation	Report of a survey of professionals who have sought help for individuals with co-occurring mental health and substance misuse conditions Joint care pathway and protocol and workforces trained
4.3 People experiencing homelessness	• Review of data for suicides for people experiencing homelessness or housing issues • Development of plan to reduce suicide risk in rough sleepers and homeless families	Data review conducted Delivery of the West Sussex mental health and housing plan
4.4 Neurodiversity	• Review of the neurodevelopmental care pathway (ADHD, ASD, dyspraxia, learning disabilities)	Pathway review conducted
4.5 LGBTQI+	• LGBTQI+ needs assessment to identify priorities for action	Needs assessment report

Key Action Area	Action	Success measures / Outputs and outcomes
5. Reduce access to means of suicide National strategy action area 6: "reduce access to means and methods"	• Development and delivery of Network Rail Hub of Hope campaign that signposts people to mental health support • Support work on suicide prevention and railways • Safe prescribing and upskilling primary care practitioners in identification and initial management of risk • Implementation of Pharmacy Quality Scheme: Suicide awareness training and action plan	Delivery of Hub of Hope campaign Workplan with railways on suicide prevention Safe prescribing and upskilling primary care practitioners in identification and initial management of risk embedded Number of practices delivering the Pharmacy Quality Scheme
6. Provide bereavement support to those bereaved and affected by a suicide National strategy action area 7: "provide effective bereavement support to those affected by suicide"	• Provision for bereavement support for those bereaved and affected by a suicide • To scope and plan an all age needs assessment for bereavement support for all those bereaved in Sussex • Ongoing work with the media in delivering sensitive details and adhering to guidance on responsible reporting	Delivery of bereavement support, annual reports and evaluations Needs assessment scope and plan developed Work with media regarding responsible reporting

Key Action Area	Action	Success measures / Outputs and outcomes
7.Use of data to support planning, response and learning National strategy action area 1: "improve data and evidence"	• Ongoing development and implementation of the Real Time Surveillance (RTS) system and response, analysis of data to inform action to limit the impact of a suspected suicide • Alignment of RTS working across Sussex • Incident debriefs and sharing of learning	RTS monthly and annual review Aligned response structures Sharing of learning with services
8. Training National Strategy action area 8: "Making Suicide everybody's business"	• Development of training needs analysis for training on suicide prevention across multiple agencies: NHS, WSCC, educational settings, voluntary sector, and first responders (police, fire brigade, ambulance, coast guard) • Development and delivery of training programmes	Training needs analysis report Training programmes delivered
9. Reduce risk of self-harm National Strategy action area 2: "provide tailored support to priority groups"	• Working with partners across health and care system including in multi-agency steering groups to reduce risk of self-harm • Delivery of Self Harm Learning Network training for professionals working with at-risk groups and parents, families and carers. Forthcoming training and information to cover neurodiversity including learning disability, autism, ADHD, body dysmorphia and eating disorders	Training reports Review and update the Managing self-harm guidance and toolkit for schools

7. Glossary of terms

ACE	Adverse Childhood Experiences
ADHD	Attention deficit hyperactivity disorder
ASD	Autistic Spectrum Disorder
CAB	Citizens Advice Bureau
CYP	Children and Young People
DPH	Director of Public Health
HEE	Health Education England
HWB	Health and Wellbeing Board
ICB	Integrated Care Board
ICS	Integrated Care System
LGBTQI+	Lesbian, Gay, Bisexual, Transgender, Querying (or Queer), Intersex, plus
MHRA	Medical and Health Care Products Regulatory Agency
NCISH	National Confidential Inquiry into Suicide and Safety in Mental Health
OHID	Office for Health Improvement and Disparities
PCN	Primary Care Network
RTS	Real Time Surveillance
SECAmb	Southeast Coast Ambulance Service
SHLN	Self-harm Learning Network
SPFT	Sussex Partnership NHS Foundation Trust
VCSE	Voluntary Community Social Enterprise
WSCC	West Sussex County Council

8. Acknowledgements

Lead Authors:
Nicola Rosenberg, Consultant in Public Health
Sara Corben, Interim Consultant in Public Health

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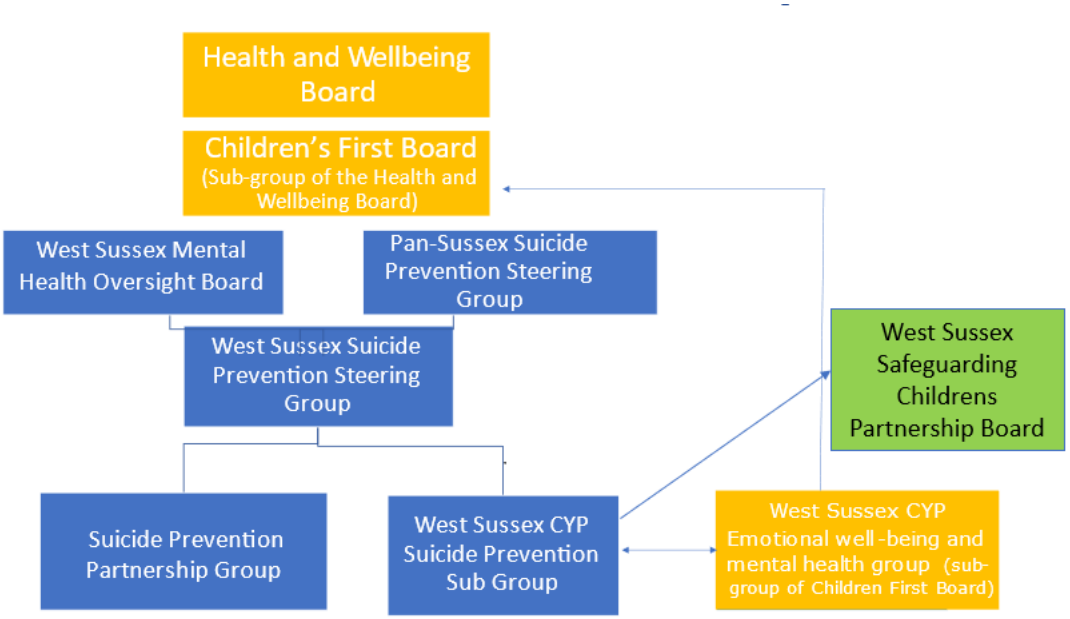
Greg Slay, Adults' Services, WSCC
Alison Thomson, Public Health, WSCC
Danielle Wilkinson, Public Health, WSCC

Appendix 1: Governance structure West Sussex Suicide Prevention Framework and action plan 2023 - 2027



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Report to West Sussex Health and Wellbeing Board

25 January 2024

Developing a strategic approach to food and nutrition across West Sussex

Report by: Alison Challenger, Director of Public Health

Summary

This report accompanies a verbal presentation, which will be delivered to the West Sussex Health and Wellbeing Board focusing on the link between the complex food landscape, the impact on population food consumption, and the effect poor nutrition can have on health and wellbeing.

The presentation will set out the intention and need to develop a strategic whole systems approach to food and nutrition for all ages across West Sussex to improve the health of the local population and reduce inequalities. Central to this, is a proposed West Sussex Food and Nutrition Strategic Framework for system wide action, to be developed across all partners, informed by a West Sussex Food and Nutrition Needs Assessment and a review of best practice evidence.

Recommendation(s) to the Board

The Health and Wellbeing Board is asked to;

(1) Provide feedback on the proposed West Sussex Food and Nutrition Strategic Framework for implementing a whole systems approach across the county.

(2) Endorse the proposed approach to address the complex food and nutrition landscape in West Sussex, including prioritising actions within an interim action plan to tackle the food environment and impact on population food consumption in the county, undertaking a West Sussex Food and Nutrition Needs Assessment to inform the development of the West Sussex Food and Nutrition Strategic Framework, and reviewing best practice evidence.

(3) To discuss the intentions for this strategic approach with their own organisations and consider how to engage with the development of the interim action plan, needs assessment and strategic framework going forward to maximise this collaborative approach.

(4) Recognise the significant impact this proposed whole systems approach across West Sussex could have on improving the health of the local population and reducing inequalities across the life course (all ages).

Relevance to Joint Health and Wellbeing Strategy

The West Sussex Joint Health and Wellbeing Strategy (JHWS) 2019-2024 refers to maximising opportunities for prevention across the life course (all ages).

Intentions to tackle overweight and obesity are mentioned most frequently in the Starting Well theme of the JHWS, with reference to prevention and risk factors across the life course.

The Living and Working Well theme includes the aim to ensure people can look after their own health and wellbeing with reference to diet as a risk factor and the importance of environments which encourage healthy choices.

1 Background and context

1.1 Detailed background and context will be included in the verbal presentation to be delivered to the Board on 2 November 2023.

2 Proposal Details

2.1 The purpose of this report is to outline the intention and need to develop a strategic whole systems approach to food and nutrition for all ages across West Sussex to improve the health of the local population and reduce inequalities.

2.2 Also, to make recommendations to the Board preparing it to participate in the development of the strategic approach.

2.3 Views are sought on this and the detailed content of the verbal presentation that will be delivered on 2 November 2023.

3 Consultation, engagement and advice

3.1 Consultation and engagement will be aligned with the development of the West Sussex Joint Local Health and Wellbeing Strategy (JLHWS) for the next period (to be published in 2024) and will include all internal and external stakeholders.

3.2 Advice will be sought throughout this process and will include representatives from the Office for Health Improvement and Disparities (OHID).

Contact:
Dr Kate Bailey, Consultant in Public Health, Tel: 0330 222 8688 Email: kate.bailey@westsusssex.gov.uk

Dr Sam Taplin, Consultant in Public Health, Email: samantha.taplin@westsussex.gov.uk

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Appendices

None

Background papers

None

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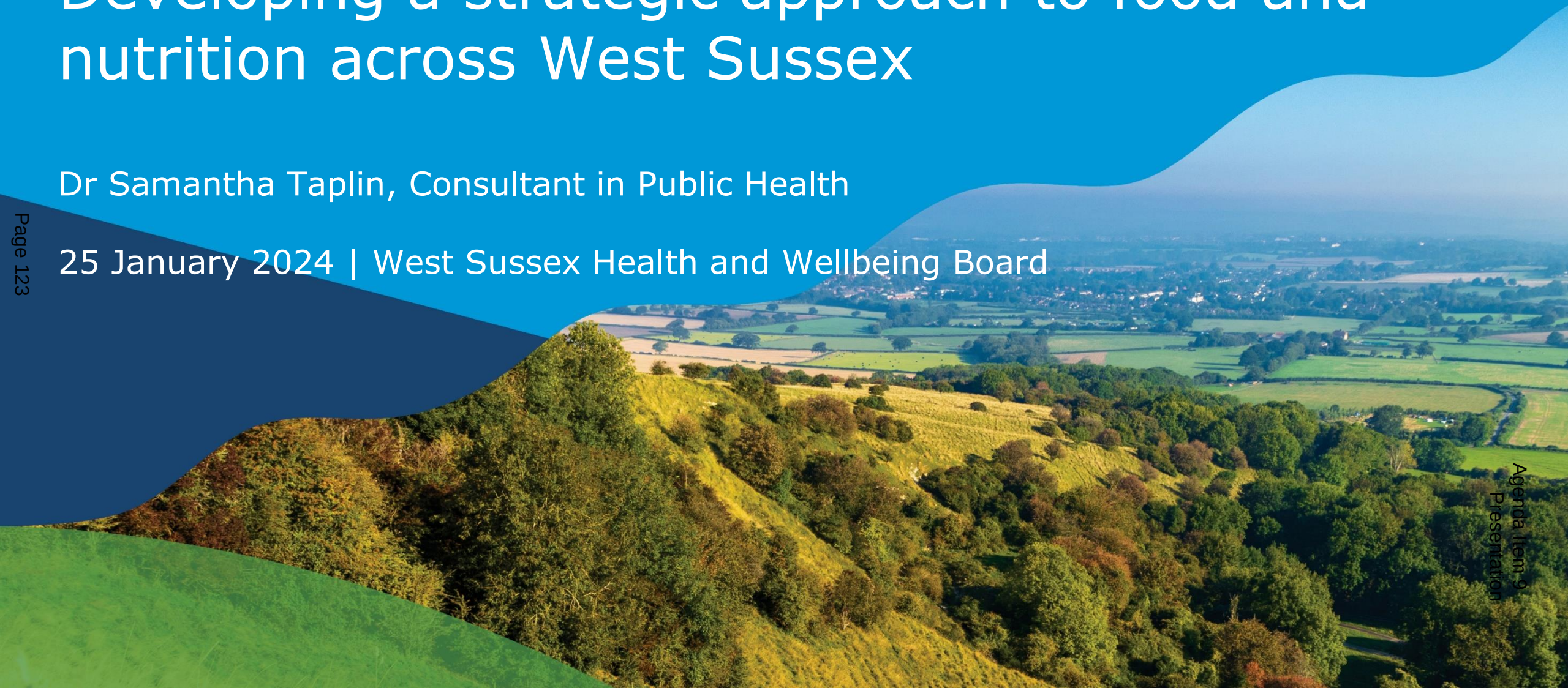
westsussex.gov.uk

Developing a strategic approach to food and nutrition across West Sussex

Dr Samantha Taplin, Consultant in Public Health

25 January 2024 | West Sussex Health and Wellbeing Board



Agenda Item 9
Presentation

Outline of presentation

Today's presentation will focus on:

1. Background and context - impact of food environment on population food consumption
2. National policy on food and nutrition
3. Health impacts of an unbalanced diet
4. Developing a strategic approach to food and nutrition across West Sussex
5. Recommendations

Purpose of discussion

Developing a strategic approach to food and nutrition across West Sussex

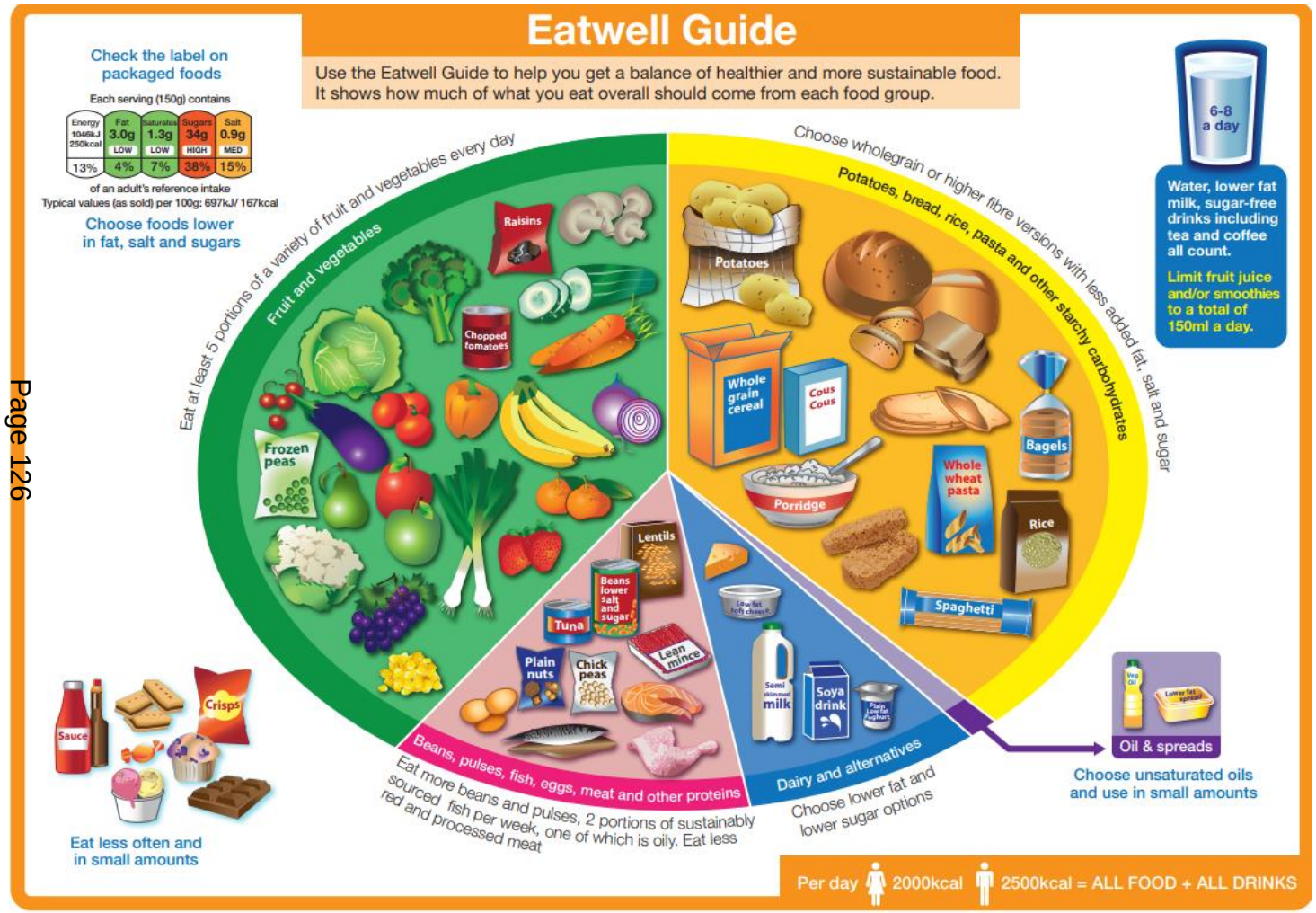
It is proposed to:

- Develop a **West Sussex Food and Nutrition Strategic Framework** for system wide action, to be developed across all partners
- Develop an **interim action plan** to tackle the food environment and impact on population food consumption in the county

To assess population need to inform development of the strategic framework, we propose to:

- Undertake a **West Sussex Food and Nutrition Needs Assessment**
- **Review best practice evidence**

The Eatwell Guide



"The Eatwell Guide shows how much of what we eat overall should come from each food group to achieve a healthy, balanced diet.

You do not need to achieve this balance with every meal, but try to get the balance right over a day or even a week."

Source: NHS: [The Eatwell Guide - NHS (www.nhs.uk)]

Health impacts of an unbalanced diet

Human nutrition and the food we eat is an important aspect of health and wellbeing and closely linked to a wide range of health outcomes

Malnutrition (meaning "poor nutrition") is a serious condition that happens when your diet doesn't contain the right amount of nutrients

It can refer to:

- Undernutrition – not getting enough nutrients
- Overnutrition – getting more nutrients than needed

Source: NHS: [Malnutrition - NHS (www.nhs.uk)]

Why is a healthy diet important?

- 60,000 deaths in England attributed to poor diets in 2019
- Diets low in nutritious * whole foods and high in sugar and ** ultra-processed foods (UPFs) are independently associated with a range of health impacts, including an increased risk of:
  - Some cancers
  - Hypertension (high blood pressure)
  - Poor oral health
  - Premature death

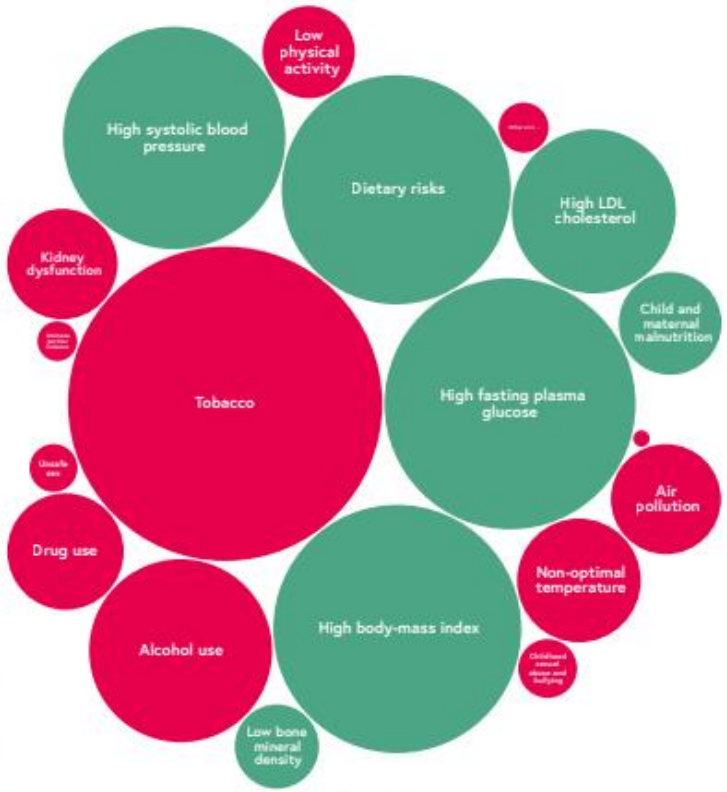
**Whole foods are foods that has been processed or refined as little as possible and is free from additives or other artificial substances.*

***Ultra processed foods (UPFs) are foods that are highly altered and typically contain a lot of added salt, sugar, fat, and industrial chemical additives.*

WHY IT MATTERS

National Food Strategy

Four of the top five risk factors for all-cause DALYs are related to diet



Note: Bubble size is proportional to DALYs. Diet related risks shown in green.

DALYS = disability adjusted life years

DALYs measure the total years lost to early death, ill-health and disability – thus combining mortality and morbidity.

They show that for England, diet is the leading cause of avoidable harm to our health.

SOURCE: Global Burden of disease, 2019 data. Accessed March 2021 GBD Results Tool | GHDx (healthdata.org)

Diet is the leading cause of avoidable harm to our health (DALYs)

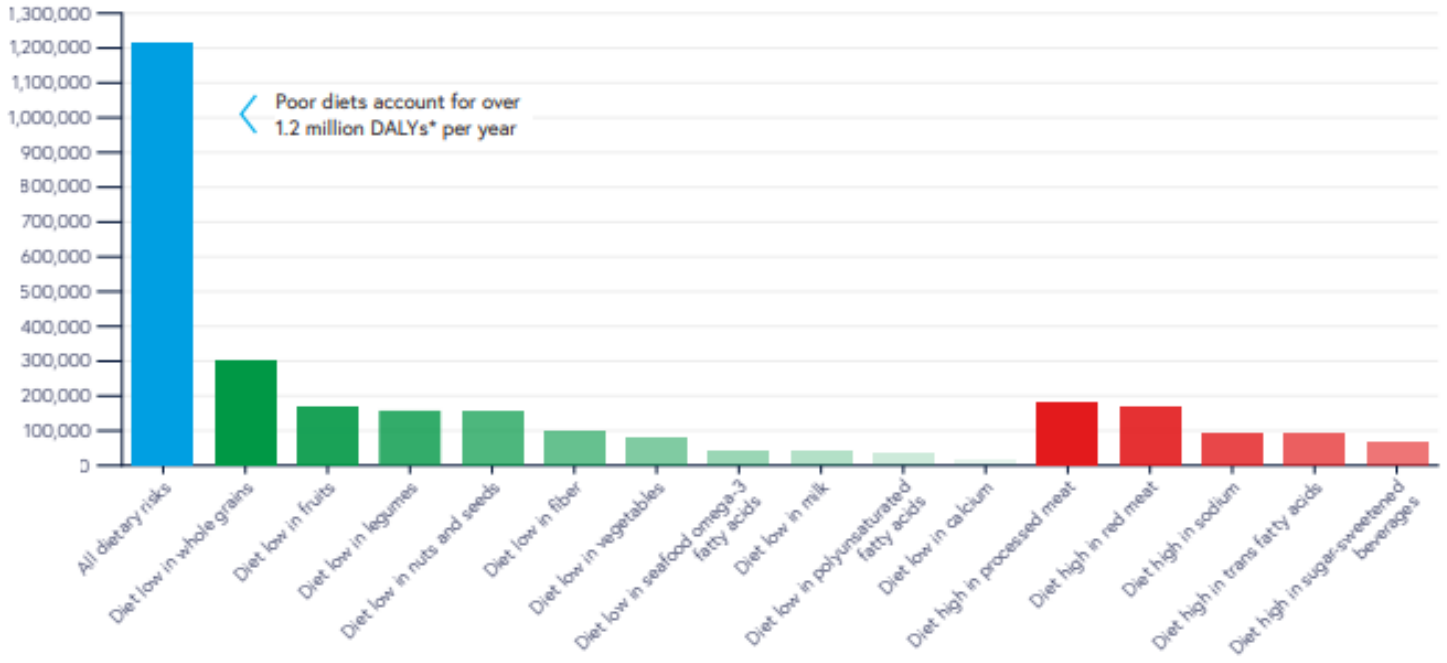
Poor diet is linked to:

- high blood pressure
- high fasting plasma glucose
- high BMI
- low bone mineral density
- high cholesterol
- child and maternal malnutrition.

WHY IT MATTERS

National Food Strategy

The problem is not just obesity, but poor diet. Both result in considerable disease risk



High BMI accounts for over 1.4 million DALYs (not on chart).

Several other disease risks, in addition to high BMI and specific diet risks, also have strong diet-related causes such as High plasma glucose and High blood pressure which are not captured here.

SOURCE: Global Burden of disease, 2019 data. Accessed March 2021 GBD Results Tool | GHDx (healthdata.org)

Background and context – food and nutrition

National Policies

- Foresight Report: Tackling Obesities: Future Choices – Project Report (2007)
- National Obesity Strategy (2020)
- UK National Food Strategy Independent Review: Part 2 (2021)
- Major Conditions Strategy (in development)

National Food Strategy for England (2021)

National Food Strategy: Independent Review: Part 2 The Plan

Key points

- Independent review of England's food chain from field to fork
- Includes production, marketing, processing, sale and purchase of food….
- Report makes recommendations to Government:

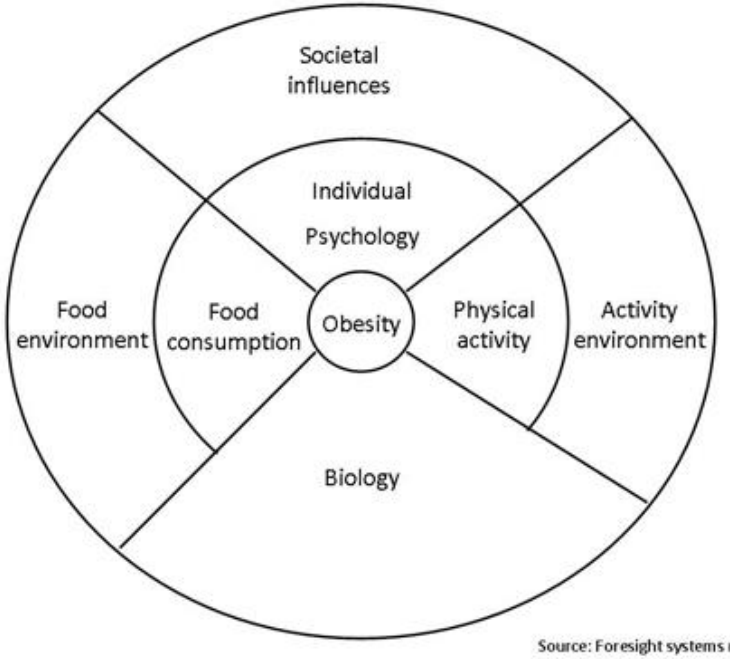
1. Escape the junk food cycle and protect the NHS
2. Reduce diet-related inequality
3. Make the best use of our land
4. Create a long-term shift in our food culture

Major Conditions Strategy

Focuses on developing a comprehensive approach to addressing **six groups of conditions,** which together account for over 60% of ill health and early death in England:

- Cancers
- Cardiovascular disease (including stroke and diabetes)
- Musculoskeletal disorders
- Mental ill health
- Dementia
- Chronic respiratory disease

Foresight Report: Tackling Obesities: Future Choices – Project Report (2007)



Source: Foresight systems map, 2007

Key Points

- Diet is interlinked with obesity as one of the main causal factors
- Traditional approaches to address obesity focus on treatment and support to those already overweight or obese
- Real impact can be seen by addressing **wider whole system determinants**
- Create conditions for positive health and wellbeing & reduce obesogenic environment
- Food environment & food consumption are two key determinants where local authority can have an impact

National data

National Diet and Nutrition Survey Data (NDNS) Rolling Programme (2016/17 – 2018/19) is the main source of data

- Continuous cross-sectional survey designed to assess the diet, nutrient intake and nutritional status of the general population in the UK.
- Keys finding where consumption in the UK population exceeds the government recommendation:
  - Free sugars was above 5% of total energy across all age groups.
  - Saturated fat was above 10% total energy across all age groups.

Diet and inequalities

- In 2018 fewer than 3 in 10 adults in England ate the recommended five portions a day of fruit and vegetables
- Low fruit and vegetable consumptions is found more likely in those living in the most deprived areas
- The UK population eats more highly processed foods than any other European country
- UK children aged 11-18 consumed more than double the recommended limit of free (added) sugars in 2016-2019
- Food poverty and insecurity has increased since the pandemic, with 2.5 million people using food banks in 2020/21- a 33% annual increase

Addressing the leading risk factors for ill health - The Health Foundation

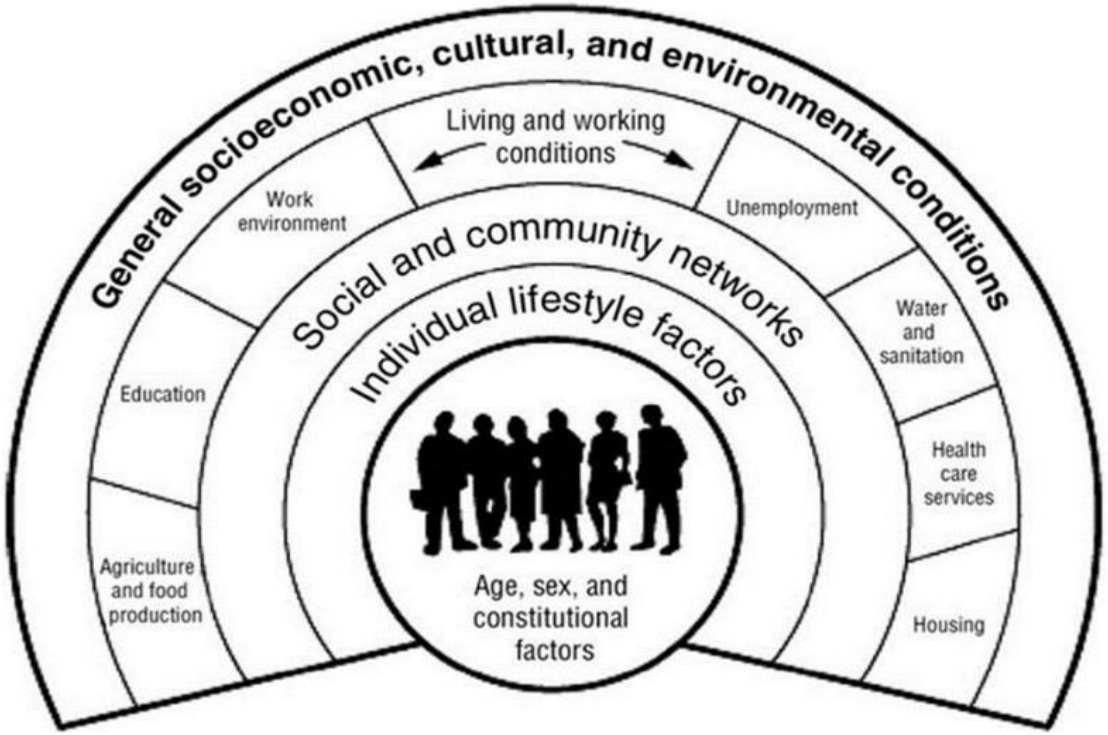
How can we prevent poor nutrition?

- Eat a healthy, balanced diet
- Eat a variety of foods from the main food groups, including:

  -plenty of fruit and vegetables
  -plenty of starchy foods e.g. bread, potato, pasta, rice
  -some milk and dairy foods or non-dairy alternatives
  -some sources of protein e.g. meat, eggs, fish, beans

Source: NHS: [Malnutrition - NHS (www.nhs.uk)]

Dahlgren and Whitehead model of health determinants (1991)



Source: Dahlgren and Whitehead (1991)

The broad social and economic circumstances that together determine the quality of the health of the population – known as the **'social determinants of health'**

Reference: Public Health England. Health profile for England 2017: Chapter 6: social determinants of health [Internet]. 2017 [accessed 2024 Jan 12]. Available from: https://www.gov.uk/government/publications/health-profile-for-england/chapter-6-social-determinants-of-health

How can we address this in West Sussex?

Developing a strategic approach to food and nutrition across West Sussex

It is proposed to:

- Develop a **West Sussex Food and Nutrition Strategic Framework** for system wide action, to be developed across all partners
- Develop an **interim action plan** to tackle the food environment and impact on population food consumption in the county

To assess population need to inform development of the strategic framework, we propose to:

- Undertake a West Sussex Food and Nutrition Needs Assessment
- Review best practice evidence

Recommendation(s) to the Board

The Health and Wellbeing Board is asked to;

(1) **Provide feedback** on the proposed West Sussex Food and Nutrition Strategic Framework for implementing a whole systems approach across the county.

(2) **Endorse** the proposed approach to address the complex food and nutrition landscape in West Sussex, including prioritising actions within an interim action plan to tackle the food environment and impact on population food consumption in the county, undertaking a West Sussex Food and Nutrition Needs Assessment to inform the development of the West Sussex Food and Nutrition Strategic Framework, and reviewing best practice evidence.

(3) **To discuss** the intentions for this strategic approach with their own organisations and consider how to engage with the development of the interim action plan, needs assessment and strategic framework going forward to maximise this collaborative approach.

(4) **Recognise** the significant impact this proposed whole systems approach across West Sussex could have on improving the health of the local population and reducing inequalities across the life course (all ages).

The proportion of the DALY burden for the 6 groups of Major conditions attributable to key risk factors *(Global Burden of Disease)*

Key risk factors	Cardiovascular Disease	Chronic Respiratory Disease	Neurological disorders	Cancers	Diabetes	Musculoskeletal disorders
High fasting plasma glucose (blood sugar levels)	25%	Not applicable	5%	6%	100%	Not applicable
Tobacco	20%	45%	6%	28%	17%	12%
High BMI	22%	6%	6%	7%	58%	7%
Dietary risks	35%	Not applicable	Not applicable	6%	37%	Not applicable
High systolic blood pressure	45%	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
High LDL cholesterol	26%	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
Occupational risks	Not applicable	8%	Not applicable	9%	Not applicable	7%
Air pollution	5%	5%	Not applicable	1%	9%	Not applicable
Non-optimal temperature	6%	11%	Not applicable	Not applicable	2%	Not applicable
Low physical activity	4%	Not applicable	Not applicable	1%	11%	Not applicable
Kidney dysfunction	6%	Not applicable	Not applicable	Not applicable	Not applicable	0%
Alcohol use	1%	Not applicable	2%	6%	-3%	Not applicable

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Report to West Sussex Health and Wellbeing Board

25 January 2024

Better Care Fund Monitoring Q2 2023-24

Report by Chris Clark, Joint Strategic Director of Commissioning, West Sussex Clinical Commissioning Group and West Sussex County Council

Summary

This paper provides an update on Better Care Fund (BCF) Planning for 2023-25, presents the Better Care Fund Q3 Quarterly Report for approval and the Q2 Quarterly Report for information, and summarises performance against the Better Care Fund national metrics for Quarter 2 2023-24.

Recommendation(s) to the Board

The Health and Wellbeing Board is asked to:

1. Note the update on the West Sussex Better Care Fund Plan 2023-25.
2. Note the Better Care Fund Q2 Quarterly Report
3. Note the West Sussex performance against the national BCF metrics at Q1 2023-24.

Relevance to Joint Health and Wellbeing Strategy

The Better Care Fund supports partnership working across the West Sussex Health and Social Care system. The funded schemes include multi-disciplinary teams delivering proactive community-based care, services for carers, social prescribing, and a broad range of adult social care services.

Background

The Better Care Fund (BCF) is one of the government's national vehicles for driving health and social care integration. It requires integrated care boards (ICBs) and local government to agree a joint plan, owned by the health and wellbeing board (HWB). These are joint plans for using pooled budgets to support integration, governed by an agreement under section 75 of the NHS Act (2006).

The programme supports local systems to successfully deliver the integration of health and social care in a way that supports person-centred care, sustainability and better outcomes for people and carers.

West Sussex Better Care Fund Plan 2023-25

A refresh of the submitted two-year plan, confirming or updating expenditure and activity plans, the setting of metrics targets for 2024-25, and capacity and demand plans for intermediate care services in 2024-25 is required during Q4 2023-24.

The updated planning requirements will require the submission of a planning template but no change to the previously submitted Better Care Fund Narrative Plan for 2023-25 is anticipated.

Better Care Fund Quarterly Reporting Q2 2023-24

The Q2 Quarterly Report consists of the following:

- Confirmation that BCF national conditions continue to be met
- Metrics commentary for Q1 2023-24
- A revised capacity and demand plans for intermediate care services covering the period November 2023 to March 2024

HWB is asked to note this report which was submitted on the authority of the chair due to the timing of the submission.

Better Care Fund Performance Q2 2023-24

Appendix 3 shows performance at Q122023-24 for the following metrics:

- Metric 1: Long term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population.
- Metric 2: Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/ rehabilitation services.
- Metric 3: Unplanned hospitalisation for chronic ambulatory care sensitive conditions.
- Metric 4: Discharge to usual place of residence.
- Metric 5: Emergency hospital admission due to falls (aged 65 and over)

Contact: Paul Keough, Better Care Fund Manager, NHS Sussex Integrated Care Board and West Sussex County Council, 07920 817577, paul.keough@nhs.net

Appendices Presentation Papers

Appendix 1: BCF Q2 Quarterly Report 2023-24 Summary Paper

Appendix 2: Better Care Fund Metrics Report Q2 2023-24

Background Papers

https://www.gov.uk/government/publications/better-care-fund-policy-framework-2023-to-2025

Report to West Sussex Health and Wellbeing Board

25 January 2024

Better Care Fund Monitoring Q2 2023-24

Appendix 1: BCF Q2 Quarterly Report 2023-24 Summary Paper

Summary

This paper summarises the approved BCF Q2 Quarterly Report submitted on 31 October 2023. The paper is necessitated by the complex formatting of the Excel report which cannot be presented in PDF or other suitable formats.

The guidance and cover sheet are omitted for brevity, but all following information is drawn directly from the report with no omissions or additions.

National Conditions

The report confirmed that West Sussex continued to meet the following national conditions:

1. Jointly agreed plan
2. Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer
3. Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time
4. Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services.

Confirmation that the BCF section 75 agreement was due to be signed-off on 20 November 2023.

Metrics

Metric	Definition	Q1 Actual	Assessment of progress against the metric plan for the reporting period	Challenges and any support needs	Achievements - including where BCF funding is supporting improvements
Avoidable Admissions	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i) **2023/24 Plan:** **Q1:** 142.9 **Q2:** 120.3 **Q3:** 117.8 **Q4:** 120.2	134.4	On track to meet target	At Q1 2023/24 the avoidable admission rate is below the planned figure of 142.9. In both 2021/22 and 2022/23, the highest figures were recorded in Q1 and, if this trend continues, the target will be met.	N/A

Metric	Definition	Q1 Actual	Assessment of progress against the metric plan for the reporting period	Challenges and any support needs	Achievements - including where BCF funding is supporting improvements
Discharge to normal place of residence	Percentage of people who are discharged from acute hospital to their normal place of residence **2023/24 Plan:** **Q1:** 88.8% **Q2:** 88.5% **Q3:** 88.5% **Q4:** 88.8%	90.6%	On track to meet target	N/A	At Q1 2023/24 performance remains above target and has improved over 7 successive quarters.

Metric	Definition	Q1 Actual	Assessment of progress against the metric plan for the reporting period	Challenges and any support needs	Achievements - including where BCF funding is supporting improvements
Falls	Emergency hospital admissions due to falls in people aged 65 and over, directly age standardised rate per 100,000 **2023/24 Plan:** 2,058.1	561.2	Not on track to meet target	At Q1 2023/24 the Falls rate is above the planned figure of 514.5. However, it is below the 5-year average for Q1, and the average figure for all quarters over the past 4 years. In both 2021/22 and 2022/23, the highest figures were recorded in Q1. Therefore, it is possible that performance in the subsequent quarters of 2023/24 will still bring performance within plan, which assumed a 3% reduction quarter on quarter, when taken over the year as a whole.	N/A

Metric	Definition	Q1 Actual	Assessment of progress against the metric plan for the reporting period	Challenges and any support needs	Achievements - including where BCF funding is supporting improvements
Residential Admissions	Rate of permanent admissions to resdential care per 100,000 population (65+) **2023/24 Plan:** 500	N/A	On track to meet target	In-year local data indicates that we are on track to meet this target. Adult Social care are continuing to work towards reducing new admissions to residential settings, while increasing non-residential options. This has been effective and the percentage of res to non-res customers has been moving in the right direction, however the average cost of placements is increasing, due to market pressures and complexity of customer need.	N/A

Metric	Definition	Q1 Actual	Assessment of progress against the metric plan for the reporting period	Challenges and any support needs	Achievements - including where BCF funding is supporting improvements
Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services **2023/24 Plan:** 68.2%	N/A	Not on track to meet target	In-year local data indicates that performance continues to be below the target set and this metric, no longer part of the Adult Social Care Outcomes Framework, is problematic as recognised in the ADASS review. There has been an increase to the level of dependence and complexity of people referred to the reablement service over the last 12 months. This is due to an increase in dependency in the relevant population, particularly those being discharged from hospital, and also an increased focus on ensuring as many people as possible benefit from referral to a reablement service, so a wider application of the criteria for the service.	An alternative measure for Reablement of 'Adults that did not receive long term support after a period of reablement support' reflects the proportion of new clients who received short-term services during the year, where no further request was made for ongoing support. Since short-term services aim to reable people and promote their independence, this measure provides evidence of a good outcome in delaying dependency or supporting recovery. For Q1 2023/24 this recorded an actual of 81.7% against an annual target of 85.5% with the performance trajectory improving when compared to 2022/23.

Capacity and Demand - Assumptions

1. How of your estimates for capacity and demand changed since the plan submitted in June: Please include how learning from the last 6 months was used to arrive at refreshed projections?
We refreshed capacity with latest available information and accounted for changes in current service provision. There are no significant changes to the demand projections.

2. Please outline assumptions used to arrive at refreshed projections (including to optimise length of stay in intermediate care and to reduce overprescription of care.) Please also set out your rationale for trends in demand for the next 6 months (e.g. how have you accounted for demand over winter?)
Demand:
Hospital Discharge: Patients are assessed following discharge for ongoing care into a service which provides rehabilitation and reablement. These patients are denoted in the below as rehabilitation. Planning submission for Sussex ICB was (as per guidance) based upon UHSx and ESHT. The below also includes estimated discharges from SaSH and community services. Figures are included where available and validated. Where supporting information allows for estimate they have been included, but services do not neatly fall into these categories.
Capacity:
The position was adjusted based on latest available data and signed off winter plans.

3. What impact have your planned interventions to improve capacity and demand management for 2023-24 had on your refreshed figures? Has this impact been accounted for in your refreshed plan?
Plans for increased capacity over winter have been applied as signed off by the system.

4. Do you have any capacity concerns or specific support needs to raise for the winter ahead?
No.

5. Please outline any issues you encountered with data quality (including unavailable, missing, unreliable data.)
Not all services report on the currencies in this submission. Figures are included where available and validated. Where supporting information allows for estimate they have been included, but services do not neatly fall into these categories.

6. Where projected demand exceeds capacity for a service type, what is your approach to ensuring that people are supported to avoid admission to hospital or to enable discharge?
Not all services report on the currencies in this submission. Figures are included where available and validated. Where supporting information allows for estimate they have been included, but services do not neatly fall into these categories. Projected demand reflects the unmitigated position that does not fully take account of a number of initiatives underway locally that is taking an improvement approach to improving productivity and optimising pathways. It is believed that these efficiencies will reduce the position that has been reported. Moreover, additional schemes to improve discharge have been approved for Q3 and Q4, which are now being mobilised and will have a further positive effect.

Capacity and Demand - Hospital Discharge

Capacity - Hospital Discharge	Pre-populated from plan:					Refreshed planned capacity (not including spot purchased capacity):					Capacity that you expect to secure through spot purchasing:				
Service Area	**Nov-23**	**Dec-23**	**Jan-24**	**Feb-24**	**Mar-24**	**Nov-23**	**Dec-23**	**Jan-24**	**Feb-24**	**Mar-24**	**Nov-23**	**Dec-23**	**Jan-24**	**Feb-24**	**Mar-24**
Social support (including VCS) (pathway 0)	130	130	130	130	130	130	130	130	130	130	0	0	0	0	0
Reablement and Rehabilitation at home (pathway 1)	442	456	456	429	456	1066	1102	1102	1031	1102	0	30	30	30	30
Short-term domiciliary care (pathway 1)	23	23	23	23	23	23	23	23	23	23	0	0	0	0	0
Reablement and Rehabilitation in a bedded setting (pathway 2)	353	353	353	353	353	353	353	353	353	353	0	30	60	60	60
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	114	114	114	114	114	114	114	114	114	114	0	0	0	0	0

Demand - Hospital Discharge	Pre-populated from plan:					Refreshed expected number of referrals:				
Social support (including VCS) (pathway 0)	**Nov-23**	**Dec-23**	**Jan-24**	**Feb-24**	**Mar-24**	**Nov-23**	**Dec-23**	**Jan-24**	**Feb-24**	**Mar-24**
Total	**124**	**128**	**128**	**119**	**128**	**135.8810**	**140.4104**	**140.4104**	**131.3517**	**140.4104**
Queen Victoria Hospital NHS Foundation Trust	2	2	2	1	2	1.7156	1.7728	1.7728	1.6585	1.7728
Surrey and Sussex Healthcare NHS Trust	29	30	30	28	30	31.2551	32.2969	32.2969	30.2132	32.2969
University Hospitals Sussex NHS Foundation Trust	93	96	96	90	96	102.9103	106.3407	106.3407	99.4800	106.3407

Demand - Hospital Discharge	Pre-populated from plan:					Refreshed expected number of referrals:				
Reablement and Rehabilitation at home (pathway 1)	**Nov-23**	**Dec-23**	**Jan-24**	**Feb-24**	**Mar-24**	**Nov-23**	**Dec-23**	**Jan-24**	**Feb-24**	**Mar-24**
Total	**414**	**427**	**427**	**399**	**427**	**452.2564**	**467.3316**	**467.3316**	**437.1812**	**467.3316**
East Sussex Healthcare NHS Trust	1	1	1	1	1	0.8698	0.8988	0.8988	0.8408	0.8988
Queen Victoria Hospital NHS Foundation Trust	6	6	6	5	6	5.6992	5.8892	5.8892	5.5093	5.8892
Surrey and Sussex Healthcare NHS Trust	96	99	99	93	99	103.8270	107.2879	107.2879	100.3661	107.2879
University Hospitals Sussex NHS Foundation Trust	311	321	321	300	321	341.8603	353.2557	353.2557	330.4650	353.2557

Demand - Hospital Discharge	Pre-populated from plan:					Refreshed expected number of referrals:				
Short-term domiciliary care (pathway 1)	**Nov-23**	**Dec-23**	**Jan-24**	**Feb-24**	**Mar-24**	**Nov-23**	**Dec-23**	**Jan-24**	**Feb-24**	**Mar-24**
Total	**5**	**5**	**5**	**5**	**5**	**23.4572**	**24.2391**	**24.2391**	**22.6753**	**24.2391**
Surrey and Sussex Healthcare NHS Trust	5	5	5	5	5	5.4646	5.6467	5.6467	5.2824	5.6467
University Hospitals Sussex NHS Foundation Trust	16	17	17	16	17	17.9926	18.5924	18.5924	17.3929	18.5924

Demand - Hospital Discharge	Pre-populated from plan:					Refreshed expected number of referrals:				
Reablement and Rehabilitation in a bedded setting (pathway 2)	**Nov-23**	**Dec-23**	**Jan-24**	**Feb-24**	**Mar-24**	**Nov-23**	**Dec-23**	**Jan-24**	**Feb-24**	**Mar-24**
Total	**340**	**350**	**350**	**329**	**350**	**302.4407**	**312.5221**	**312.5221**	**292.3593**	**312.5221**
Queen Victoria Hospital NHS Foundation Trust	4	4	4	4	4	3.8186	3.9459	3.9459	3.6914	3.9459
Surrey and Sussex Healthcare NHS Trust	79	82	82	77	82	69.5668	71.8857	71.8857	67.2479	71.8857
University Hospitals Sussex NHS Foundation Trust	257	264	264	248	264	229.0553	236.6905	236.6905	221.4201	236.6905

Demand - Hospital Discharge	Pre-populated from plan:					Refreshed expected number of referrals:				
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	**Nov-23**	**Dec-23**	**Jan-24**	**Feb-24**	**Mar-24**	**Nov-23**	**Dec-23**	**Jan-24**	**Feb-24**	**Mar-24**
Total	**110**	**112**	**112**	**106**	**112**	**127.8838**	**132.1466**	**132.1466**	**123.6210**	**132.1466**
Queen Victoria Hospital NHS Foundation Trust	1	1	1	1	1	1.6147	1.6685	1.6685	1.5609	1.6685
Surrey and Sussex Healthcare NHS Trust	26	26	26	25	26	29.4156	30.3961	30.3961	28.4351	30.3961
University Hospitals Sussex NHS Foundation Trust	83	85	85	80	85	96.8536	100.0820	100.0820	93.6251	100.0820

Capacity and Demand - Community

Capacity - Community	Pre-populated from plan:					Refreshed planned capacity:				
Service Area	**Nov-23**	**Dec-23**	**Jan-24**	**Feb-24**	**Mar-24**	**Nov-23**	**Dec-23**	**Jan-24**	**Feb-24**	**Mar-24**
Social support (including VCS)	0	0	0	0	0	0	0	0	0	0
Urgent Community Response	663	663	663	663	663	1153	1153	1153	1153	1153
Reablement and Rehabilitation at home	2183	2183	2183	2183	2183	1329	1329	1329	1329	1329
Reablement and Rehabilitation in a bedded setting	0	0	0	0	0	0	0	0	0	0
Other short-term social care	0	0	0	0	0	0	0	0	0	0

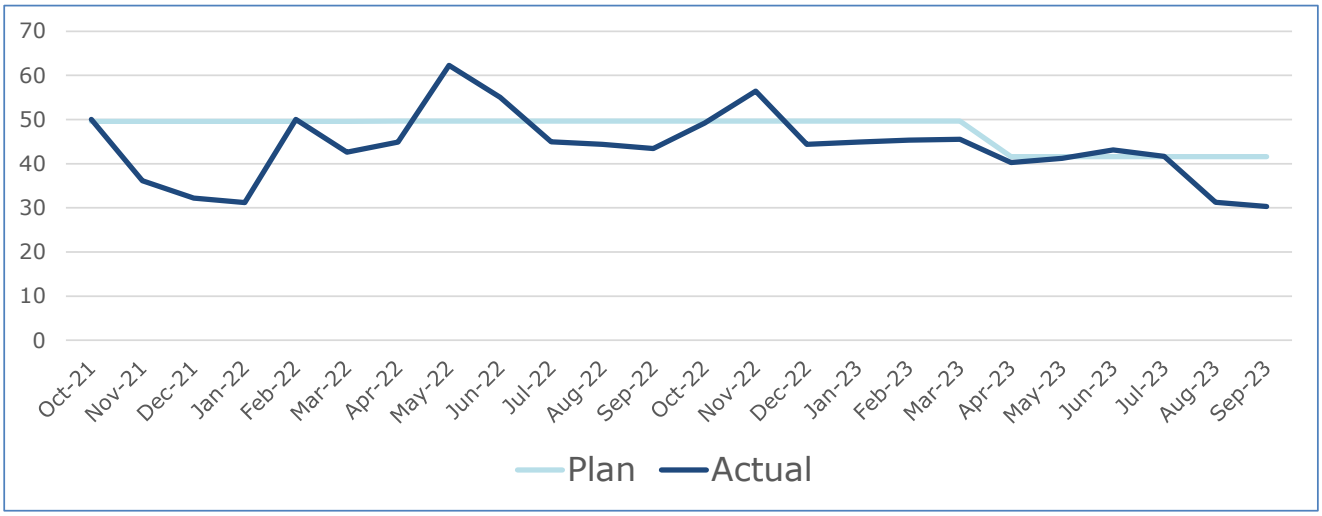
Demand - Community	Pre-populated from plan:					Refreshed expected number of referrals:				
Service Area	**Nov-23**	**Dec-23**	**Jan-24**	**Feb-24**	**Mar-24**	**Nov-23**	**Dec-23**	**Jan-24**	**Feb-24**	**Mar-24**
Social support (including VCS)	0	0	0	0	0	0	0	0	0	0
Urgent Community Response	628	649	649	607	649	1093.1250	1129.5625	1129.5625	1056.6875	1129.5625
Reablement and Rehabilitation at home	2070	2139	2139	2001	2139	1260.0417	1302.0431	1302.0431	1218.0403	1302.0431
Reablement and Rehabilitation in a bedded setting	0	0	0	0	0	0	0	0	0	0
Other short-term social care	0	0	0	0	0	0	0	0	0	0

Contact: Paul Keough, Better Care Fund Manager, NHS Sussex Integrated Care Board and West Sussex County Council, 07920 817577, paul.keough@nhs.net

HWB Better Care Monitoring 2023-24: Appendix 2: Better Care Fund Metrics Report Q2 2023-24

Permanent Admissions to Nursing and Residential Homes

Figure 1 Residential Admissions (per month) - 24 months to September 2023



2023-24 plan: Lower than 41.6 per month (average of annual target of 499.6.)

September 2023 actual: 30.3 (See note about data collection below.)

September 2022 comparison: 43.4.

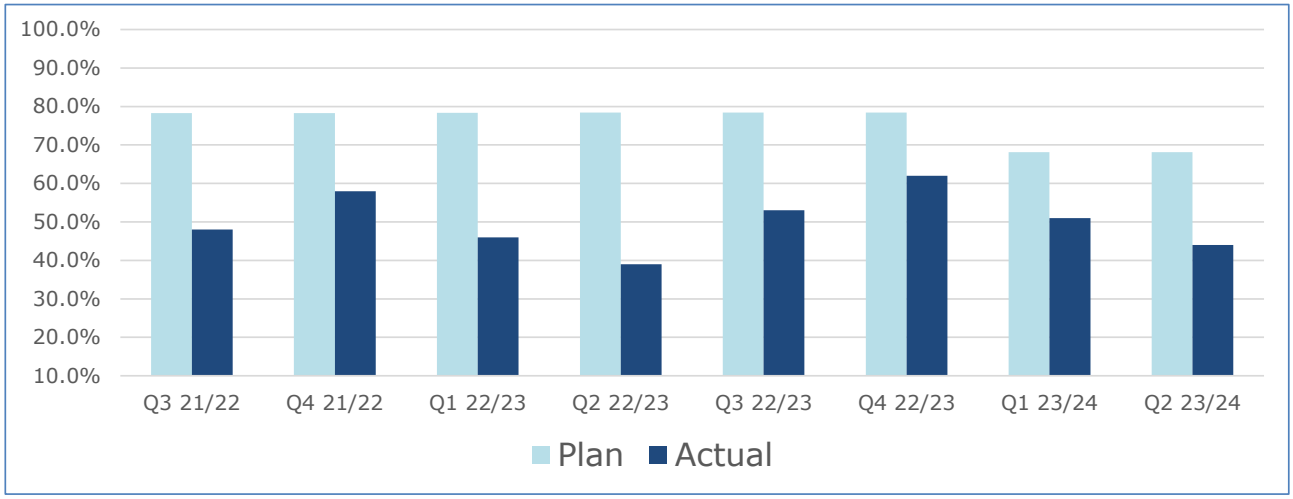
Adult Social care are continuing to work towards reducing new admissions to residential settings, while increasing non-residential options. This has been effective and the percentage of res to non-res customers has been moving in the right direction, however the average cost of placements is increasing, due to market pressures and complexity of customer need.

Due to increased demand and reduced market capacity, ASC are experiencing significant wait times in all areas of the business. This means the current performance may be impacted by individuals having to wait longer before a placement can be identified, which shows as an over estimated reduction in new admissions.

Please note that data for this metric is collected over an extended period. Hence, the most recent months will always show low figures pending full data collection.

% Of Older People at Home 91 Days after Discharge into Reablement/Rehabilitation Services

Figure 2 Reablement (% 65+ at home 91+ days post-discharge) - 24 months to Q2 2023-24



2023-24 plan: Higher than 68.2 percent per month (annual target of 68.2 percent.)

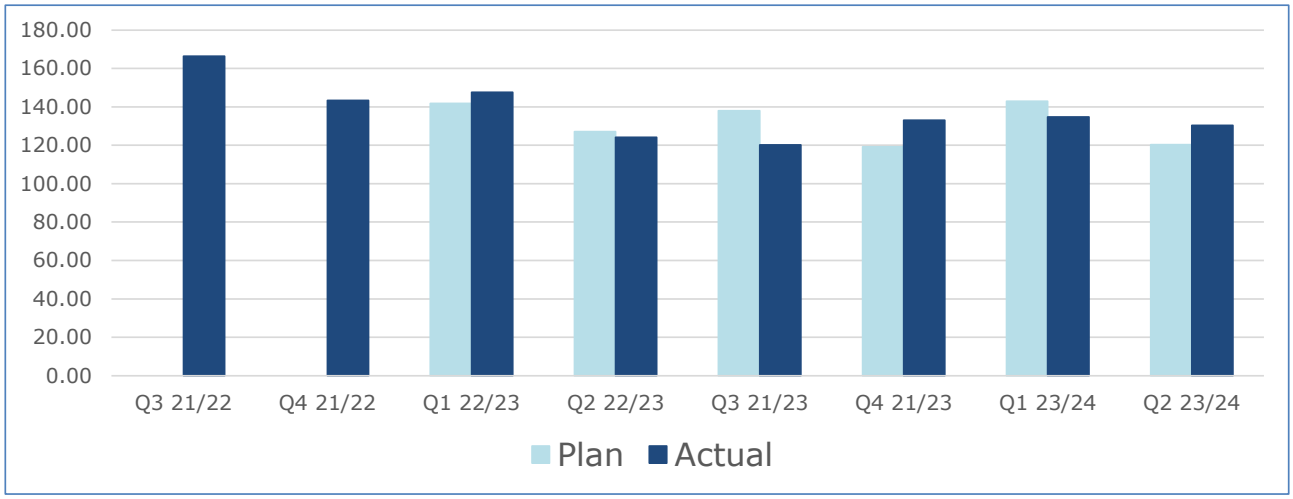
Q2 2023-24 actual: 44.0 percent.

Q2 2022-23 comparison: 39.0 percent.

There has been an increase to the level of dependence and complexity of people referred to the reablement service over the last 12 months. This is due to an increase in dependency in the relevant population, particularly those being discharged from hospital, and also an increased focus on ensuring as many people as possible benefit from referral to a reablement service, so a wider application of the criteria for the service.

Unplanned Hospitalisation for Chronic Ambulatory Care Sensitive Conditions

Figure 3 Ambulatory Case Sensitive Conditions - 24 months to Q2 2023-24



Q2 2023-24 plan: Lower than 120.3 – Indirectly standardised rate of admissions per 100,000 population.

Q2 2023-24 actual: 130.4.

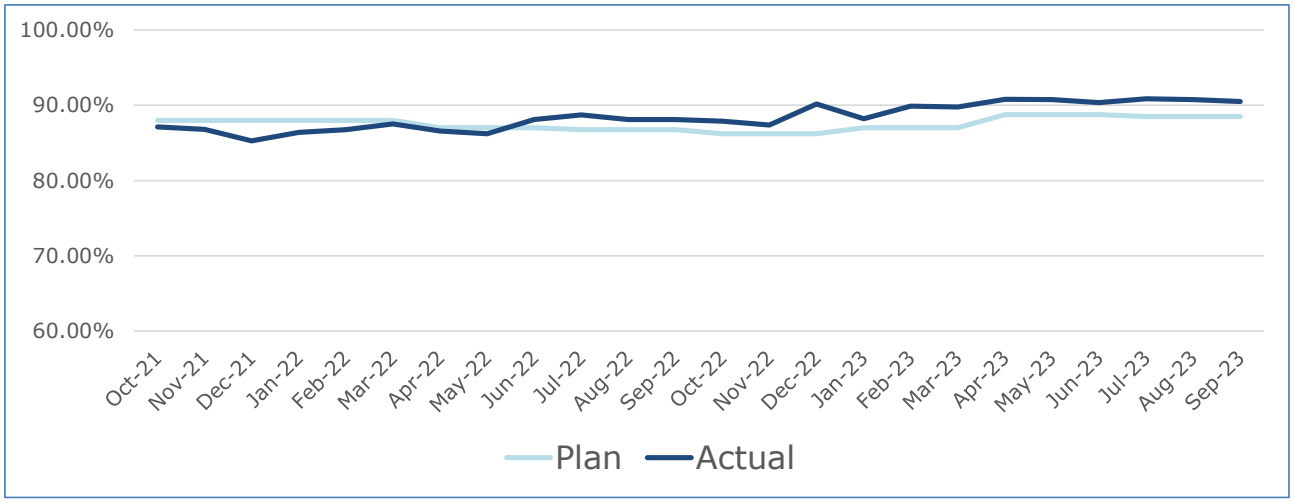
Q2 2022-23 comparison: 124.2 percent.

This metric is a measure of emergency admissions with a primary diagnosis of an ambulatory care sensitive condition such as: acute bronchitis, angina, ischaemic heart disease, heart failure, dementia, emphysema, epilepsy, hypertension, diabetes, COPD, pulmonary oedema.

At Q2 2023/24 the avoidable admission rate is 8.4% above the planned figure of 120.3 although there is not a discernible trend in the figures available to date.

Discharge to Usual Place of Residence

Figure 4 Discharge to Usual Place of Residence - 24 months to September 2023



Q2 2023-24 plan: Higher than 88.5 percent.

September 2023 actual: 90.5 percent.

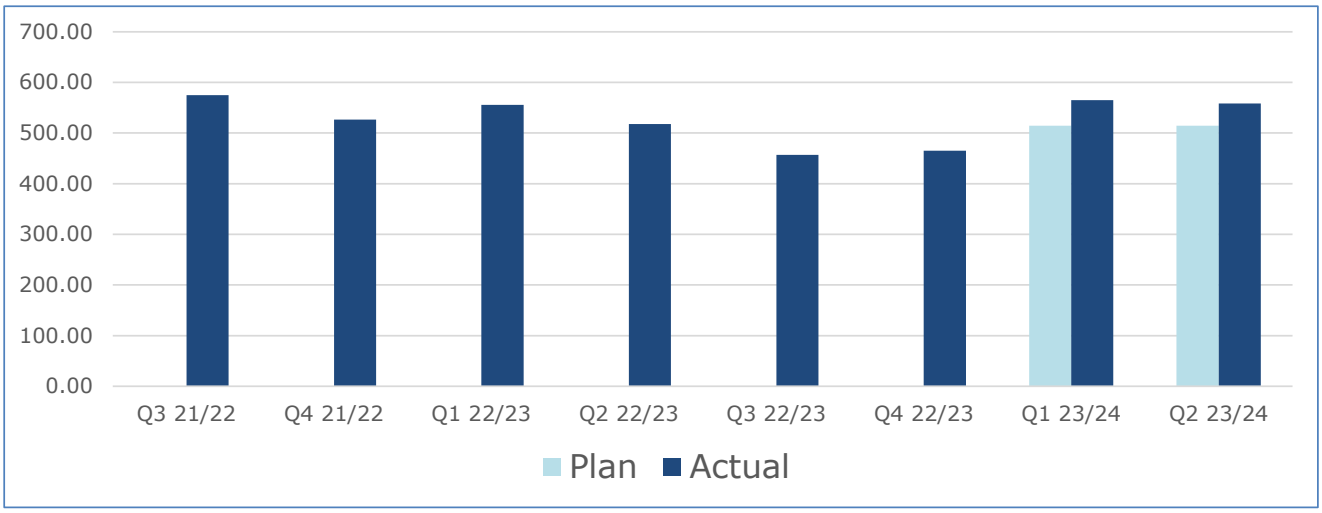
September 2022 comparison: 88.1 percent.

This measure for discharge to usual place of residence has been constructed by the national BCF team around the 95% expectation in the discharge policy for Pathways 0 and 1. However it should be noted that the policy was not intended as setting a hard target for these pathways.

This metric continues to perform above plan.

Emergency Admissions due to Falls

Figure 5 Emergency Admissions due to Falls - 24 months to Q2 2023-24



Q2 2023-24 plan: Lower than 514.5 percent.

Q2 2023-24 actual: 558.4 percent.

Q2 2022-23 comparison: 517.5 percent.

Falls are the largest cause of emergency hospital admissions for older people, and significantly impact on long term outcomes.

This indicator is an important measure around joint working between adult social care and health partners (e.g., urgent community response services) to prevent hospital admissions and reduce falls which will improve outcomes for older people and support independence.

At Q2 2023/24 the Falls rate is above the planned figure of 514.5 by 8.5%, and above a 2-year average of 527.4. However, it has fallen slightly since Q1. In both 2021/22 and 2022/23, the highest figures were recorded in Q1.

Contact: Paul Keough, Better Care Fund Manager, NHS Sussex Integrated Care Board and West Sussex County Council, 07920 817577, paul.keough@nhs.net

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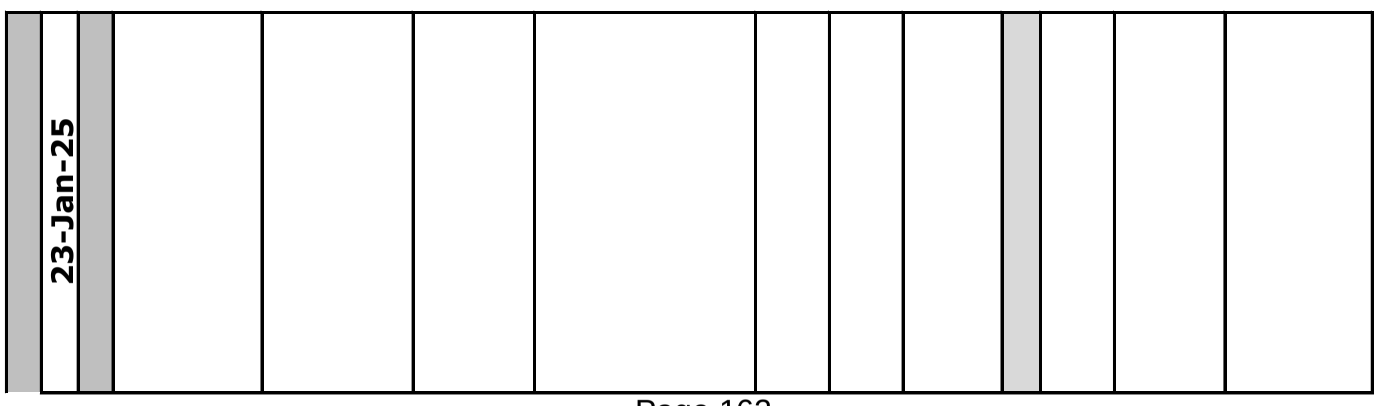
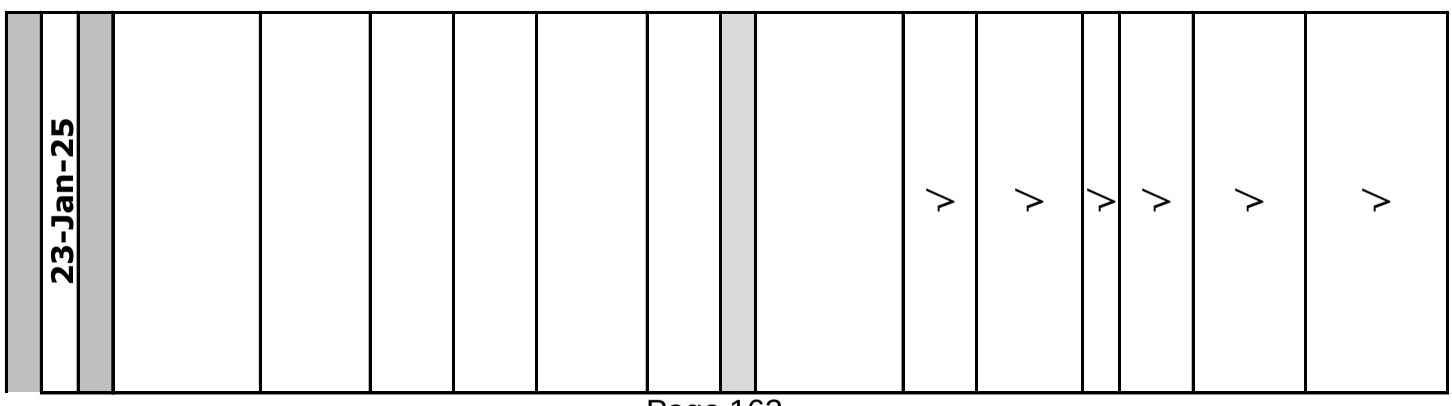
Health and Wellbeing Board (HWB) Work Programme 2024/2025				
Meeting Date	**25-Jan-24**	**25-Apr-24**	**11-Jul-24**	**07-Nov-24**
Items				
Progress update from West Sussex Housing Group on **housing and homelessness**		√		
Council's whole systems approach to **healthy weight** in West Sussex	√			
West Sussex **Suicide Prevention** Strategy and pan-Sussex Suicide Prevention Strategy progress update	√			
HWB Development		√		
Tobacco Control – (to include vaping)		√		
Joint Local Health and Wellbeing Strategy		√		
Developing a draft **Alcohol Strategy** for West Sussex				√
Annual Reports/Actions				
Terms of Reference Annual Review		√		
Safeguarding Adults Annual Report			√	
Safegaurding Childrens Annual Report	√			

Health and Wellbeing Board (HWB) Work Programme 2024/2025				
Meeting Date	**25-Jan-24**	**25-Apr-24**	**11-Jul-24**	**07-Nov-24**
Items				
Public Health Annual Report		√		
HealthWatch Annual Report			√	
Pharmaceutical Needs Assessment (formal revision due 2025)				
Joint Strategic Needs Assessment (annual summary)		√		
Health Protection Assurance Annual Report		√		
Joint Health and Wellbeing Strategy - term ends March 2024		√		
Standing Items				
On standby HWB - Local Outbreak Engagement Board				
HWB - Children First Board	√	√	√	√
Better Care Fund Monitoring	√	√	√	√
Public Forum	√	√	√	√
Public Health Update	√	√	√	√
Recommendation and Action Tracker	√	√	√	√
Integrated Care System (ICS) (Incorporating Health Inequalities)		√	√	√

Health and Wellbeing Board (HWB) Work Programme 2024/2025				
Meeting Date	**25-Jan-24**	**25-Apr-24**	**11-Jul-24**	**07-Nov-24**
Items				
HWB Prep Timetable				
Draft Papers for Agenda Prep	**03-Jan-24**	**29-Mar-24**	**14-Jun-24**	**11-Oct-24**
Agenda Prep Meeting	**05-Jan-24**	**02-Apr-24**	**17-Jun-24**	**15-Oct-24**
Date of HWB Meeting	**25-Jan-24**	**25-Apr-24**	**11-Jul-24**	**07-Nov-24**
Venue	County Hall Chichester	County Hall Chichester	County Hall Chichester	County Hall Chichester
Final Papers for Despatch	**18-Jan-24**	**17-Apr-24**	**03-Jul-24**	**30-Oct-24**


23-Jan-25


23-Jan-25


23-Jan-25
12-Dec-24
16-Dec-24
23-Jan-25
County Hall Chichester
15-Jan-25