Meeting of: Joint Health Overview and Scrutiny Committee for Pennine Care Foundation Trust

Date: Thursday 26 November 2015

Present:
Councillor McGee (Stockport MBC) (Chair)
Councillor Adams (Bury MBC)
Councillor Gartside (Rochdale MBC)
Councillor Gordon (Stockport MBC)
Councillor Rowbotham (Rochdale MBC)
Councillor McClaren (Oldham MBC)
Councillor Walker (Bury MBC)
Councillor Wright (Stockport MBC)

Apologies:
Councillor Grimshaw (Bury MBC)
Councillor Judge (Oldham MBC)
Councillor Bell (Tameside MBC)

In Attendance:
Wendy Meston – Chair of the GM Suicide Prevention Group
Dr Henry Ticehurst – Medical Director - Pennine Care NHS Foundation Trust
Matt Walsh – Head of Patient Safety - Pennine Care NHS Foundation Trust
Ben Woffenden – Complaints Manager – Pennine Care NHS Foundation Trust

PC 15/16-23 APOLOGIES

Apologies were detailed above.

PC 15/16-24 DECLARATIONS OF INTEREST

Councillors Gordon and Walker declared personal interests in all matters under consideration as they are both members of the Pennine Care Foundation Trust.

PC 15/16-25 PUBLIC QUESTIONS

There were no questions from members of the public

PC 15/16-26 MINUTES OF THE LAST MEETING

It was agreed:

The minutes of the meeting held on the 17 September 2015 be approved as a correct record.

PC 15/16-27 SUICIDE PREVALENCE AND PREVENTION

(A) Members of the Joint Health Overview and Scrutiny Committee considered a verbal presentation from Ben Woffenden, Complaints Manager, Pennine Care Foundation Trust in relation to complaints to the Trust arising from suspected suicides. The presentation contained the following information:

- According to information from the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, the number of confirmed suicides/ coroner open verdicts across the Trust footprint between 2011 and 2013 ranged from 100 to 120.
- There were difficulties in establishing how many of these individuals may have been service users of the Trust.
- The number of complaints to the Trust relating to services users who had committed suicide (as identified by the complainant) were low with on more than 3 per year since 2012/13.
- The type of issues raised in the complaints included the appropriateness of clinical care; communication with other agencies; communication with families and carer; contact with families and carers following a service user's death; the Trust's involvement in the Coroner's Inquest; the accuracy of information contained in records.
- Such complaints were challenging to respond to, given the sensitivity of the issues; the fact that someone has died; the impact on the complainant, and staff; complexity of the issues involved; fact that the complainant may not necessarily represent the whole family's view.
- The importance of learning from complaints and amending processes accordingly.

Matt Walsh, Head of Patient Safety reported that the Trust had a comprehensive suicide prevention strategy but that this would be refreshed, working closely with Local Authorities and other agencies in the districts to ensure a co-ordinated and coherent approach. He also stressed the need to ensure the Strategy was better linked to front line service provision.

Dr Henry Ticehurst, Medical Director stressed the importance of responding earlier in care pathways to detect and prevent avoidable self-harming and suicide, but highlighted that 75% of suicides were of people outside of services. A coordinated approach with Public Health services was needed to better understand population need and prevention.

The Medical Director emphasised the importance of overcoming the stigma of suicide and encouraging those with concerns to ask 'awkward' questions. He also stressed the need for consistency and coherence across services in Greater Manchester, including understanding the range of services available through the Third Sector.

(b) Members of the Joint Health Overview and Scrutiny Committee considered a verbal presentation from Wendy Meston, Chair of the GM Suicide Prevention Group, on the work of the Group and population level issues. The presentation contained the following information:-

- The work at Greater Manchester followed the themes in the national Suicide Prevention Strategy, seeking to identify what activity was best done across the entire footprint but also to reduce variation in provision and to share best practice.
- The importance of collecting data to monitor effectiveness of interventions, including 'live' data prior to coroner verdicts.
- The value of 'Post-vention' to support family members and those connected to events after a suicide.
- The work with local media organisations to handle stories about suicide sensitively and to limit details that may be copied by others.
- Working with agencies, including the Police, to identify risky areas and to

make physical changes to minimise opportunities and to signpost support services.

- Ongoing efforts to increase awareness, improve website information and develop an app.

Members of the Joint Committee then asked questions and made comments about the issues raised in both presentations and in the written material circulated with the agenda.

In response to questions about suicide within a hospital setting, the Medical Director stated that all cases of self-harm were monitored and graded so as to distinguish harming from an attempted suicide and that this data was monitored through the Trust's governance structures. Appropriate lessons were also drawn from these cases to improve processes and services.

Members acknowledged the need for training and awareness raising amongst staff in a range of public agencies and those delivering services, but questioned how widespread this could be. In response, the Medical Director and the Chair of the Suicide Prevention Group recognised the challenge and acknowledged that training was often reactive, but that basic mental health training was important in most services. There were examples of good practice in commissioning that embedded training requirements within contracts. The Police were highlighted as a key partner for whom training was vital given they may be first responders to suicides as well as the stress experienced by officers and staff in dealing with a range of difficult and distressing situations. The Crisis Concordat had been developed in part to address these concerns.

In response to questions about raising awareness in schools, it was reported that no planned population-level activity took place, although training was provided when requested, and that there was no statutory requirement for the issues to be covered in PHSE sessions. It was also commented that where a suicide took place of a young person of school age this often resulted in a clustering of other suicides and attempts, which could encourage schools to supress information rather than seek support.

Professionals acknowledged that improving resilience amongst young people may contribute to a reduction in suicide and self-harm more generally. Further comments were made about the risks associated cyber-bullying through social media and mobile technology and the increased stress this placed on young people.

Members queried the role of GPs in suicide prevention given their that for many people they were the first point of contact with NHS services. In response it was suggested that engagement of GPs in mental health issues was variable with some considering it a secondary health care issue.

Comments were made about the role of isolation and community cohesion in suicide. It was suggested that having a large family or being part of a cohesive community could provide support that minimised the risk of suicide, but it was acknowledged that such networks could inhibit people seeking help for fear of ostracism or because family members did not 'listen'.

In conclusion, Dr Ticehurst emphasised the importance of overcoming stigma and seeking to achieve parity of esteem of mental health with physical health to ensure mental health was given greater consideration in decisions about the

redesign of services. He also suggested that more monitoring of Third Sector activity in this area was needed to assess its effectiveness.

Matt Walsh stated that he would want all staff at the Trust to be able to ask appropriate suicide prevention questions and for the issue to be given similar consideration as other safeguarding concerns.

The Chair identified the following issues for further consideration:-

- how to promote training and ensuring consistency across agencies;
- expansion of the Sanctuary Programme in the East of Greater Manchester;
- the potential of Suicide Prevention Champions;
- referring the issue of suicide prevention to local scrutiny committees for consideration to understand local practice.

It was agreed:

1. That Wendy Meston, Dr Henry Ticehurst, Matt Walsh and Ben Woffenden be thanked for their attendance.
2. That the figures in relation to the number of ambulance journeys made to transfer mental health patients to out of Borough placements be provided to the Joint Health Overview and Scrutiny Officer and circulated to members of the committee.

PC 15/16-27 URGENT BUSINESS

There was no urgent business reported.