EAST SUSSEX HEALTH AND WELLBEING BOARD

TUESDAY, 12 DECEMBER 2023

2.30 PM COUNCIL CHAMBER, COUNTY HALL, LEWES

MEMBERSHIP -	Councillor Keith Glazier, East Sussex County Council (Chair) Councillor Carl Maynard, East Sussex County Council Councillor John Ungar, East Sussex County Council Councillor Trevor Webb, East Sussex County Council Councillor Margaret Bannister, Eastbourne Borough Council Councillor Teresa Killeen MBE, Rother District Council Jessica Britton, NHS Sussex Dr Stephen Pike, NHS Sussex Vacancy, NHS Sussex Mark Stainton, Director of Adult Social Care Darrell Gale, Director of Public Health Alison Jeffery, Director of Children's Services Veronica Kirwan, Healthwatch East Sussex Joanne Chadwick-Bell, East Sussex Healthcare NHS Trust
INVITED OBSERVERS WITH SPEAKING RIGHTS	Councillor Andy Batsford, Hastings Borough Council Councillor Paul Coleshill, Wealden District Council Councillor Paul Davies, Lewes District Council Becky Shaw, Chief Executive, ESCC John Willett, Sussex Police and Crime Commissioner Mark Matthews, East Sussex Fire and Rescue Service Duncan Kerr, VCSE Alliance

A G E N D A

1. Minutes of meeting of Health and Wellbeing Board held on 28 September 2023 *(Pages 3 - 10)*

2. Apologies for absence

3. Disclosure by all members present of personal interests in matters on the agenda

4. Urgent items

   Notification of items which the Chair considers to be urgent and proposes to take at the end of the agenda. Any members who wish to raise urgent items are asked, wherever possible, to notify the Chair before the start of the meeting. In so doing, they must state the special circumstances which they consider justify the matter being considered urgently

5. East Sussex Safeguarding Children Partnership (ESSCP) Annual Report 2022/23 *(Pages 11 - 60)*

6. East Sussex Shared Delivery Plan (SDP) programme update *(Pages 61 - 70)*

7. East Sussex Joint Strategic Needs Assessment (JSNA) Update *(Pages 71 - 78)*

8. Sussex and East Sussex Suicide Prevention Strategies *(Pages 79 - 170)*

9. Work programme *(Pages 171 - 172)*

10. Any other items previously notified under agenda item 4

PHILIP BAKER
Assistant Chief Executive
County Hall, St Anne's Crescent
LEWES BN7 1UE

4 December 2023

Contact Martin Jenks, Senior Scrutiny Adviser,
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NOTE: ***As part of the County Council's drive to increase accessibility to its public meetings, this meeting will be broadcast live on its website and the record archived. The live broadcast is accessible at: www.eastsussex.gov.uk/yourcouncil/webcasts/default.htm***

EAST SUSSEX HEALTH AND WELLBEING BOARD

MINUTES of a meeting of the East Sussex Health and Wellbeing Board held at Council Chamber, County Hall, Lewes on 28 September 2023.

MEMBERS PRESENT	Councillor Keith Glazier (Chair) Councillor Carl Maynard, Councillor John Ungar, Councillor Trevor Webb, Councillor Teresa Killeen MBE, Jessica Britton, Dr Stephen Pike, Mark Stainton, Darrell Gale, Alison Jeffery, Veronica Kirwan and Richard Milner
INVITED OBSERVERS PRESENT	Becky Shaw
PRESENTING OFFICERS	Seona Douglas, Interim Independent Chair East Sussex Safeguarding Adults Board. Naomi Ellis, Director of Safeguarding & Clinical Standards, NHS Sussex. Vicky Smith, Programme Director - East Sussex Health and Social Care Transformation.

11. MINUTES OF MEETING OF HEALTH AND WELLBEING BOARD HELD ON 27 JUNE 2023

11.1 The minutes of the meeting held on 27 June 2023 were agreed as a correct record of the meeting.

12. APOLOGIES FOR ABSENCE

12.1 The following apologies for absence were received from members of the Board:

- Joe Chadwick-Bell, East Sussex Healthcare Trust.
- Councillor Andy Batsford, Hastings Borough Council.

12.2 The following substitutions were made for members of the Board:

- Richard Milner substituted for Joe Chadwick-Bell.

12.3 The following apologies for absence were received from invited observers with speaking rights:

- Councillor Margaret Bannister, Eastbourne Borough Council.
- Councillor Paul Davies, Lewes District Council.
- Mark Matthews, East Sussex Fire and Rescue Service.

13. DISCLOSURE BY ALL MEMBERS PRESENT OF PERSONAL INTERESTS IN MATTERS ON THE AGENDA

13.1 Councillor Trevor Webb declared a personal non-prejudicial interest under item 8, Director of Public Health Annual Report, as he a personal friend of the project manager of The Refugee Buddy Project used as a case study in the report. Councillor Trevor Webb declared a personal non-prejudicial interest under item 9, East Sussex Shared Delivery Plan programme update, as he was part of the People Scrutiny Committee review of the use of ICT and communications in Adult Social Care and Health. Councillor Trevor Webb also declared a personal non-prejudicial interest under item 10, Creative Health Position Paper, as he is a Trustee of One Hastings Community Voice and a member of the Hastings Friendship Group.

13.2 Councillor Carl Maynard declared a personal non-prejudicial interest under item 9, East Sussex Shared Delivery Plan programme update, regarding the East Sussex Community Oversight Board as he is a member of Rother District Council.

14. URGENT ITEMS

14.1 There were none.

15. EAST SUSSEX SAFEGUARDING ADULTS BOARD (SAB) ANNUAL REPORT 2022 - 2023

15.1 The Board considered a report on the East Sussex Safeguarding Adults Board (SAB) Annual Report 2022/23. Seona Douglas, Interim Independent Chair East Sussex Safeguarding Adults Board gave a short presentation on the key points contained within the report, setting out the legal requirements, a summary of the Safeguarding Adult Reviews (SARs) activity and the five priorities contained within the report.

15.2 Board members commented that they were pleased that the issue of transitions for children to adult services, particularly for those with learning disabilities, is mentioned in theme one in the report. Board members also commented on the work under theme two, for women with multiple needs in relation to chronic trauma, drug and alcohol abuse, homelessness, and domestic abuse and the audit of the multi-agency approach to work in this area. It was noted that the Probation Service action on gaining the adults voice and views in this work.

15.3 Seona Douglas responded that although some years ago there was an issue around learning disabilities it is now much more an issue about substance abuse and mental health issues. It continues to be important to make sure the voices of residents and service users are sought and heard. Evidence from Safeguarding Adult Reviews shows this is a national issue particularly for people with mental health issues where they are not being asked their views. There is a continuing need to ensure that questions are being asked to get people's views.

15.4 The Board noted that financial abuse has become more widespread. It asked if someone with capacity who is identified as being financially abused does not want any action taken, whether there are any powers to continue to act, as is the case with the Police and domestic abuse. Also, should there be legislative change to help tackle financial abuse in situations like this where there may be coercive control.

15.5 Seona Douglas noted that there had been legislative change to help deal with domestic abuse and the Police can still sometimes find it difficult to take a case to court if someone does not want to co-operate with them. In terms of safeguarding, frontline staff do ensure people are protected from financial abuse and it is not necessarily the case that staff will stop working with people where they do not want to engage. Learning from Safeguarding Reviews means that someone saying they do not wish to engage is no longer a sufficient reason to close a case. There are other routes such as Care Act assessments where professionals can try to provide support to ensure someone is protected. There are also processes, such as multi agency panels, where agencies come together to try and provide wrap around support for someone in order to find a solution. The Care Act is currently being reviewed to consider giving statutory powers of entry to local authority social workers, which is currently being debated in the sector. Local authorities already have a degree of autonomy to work with people to help protect them and Seona was not sure that a change in the law would help, given the need to balance the individual's rights and the use of statutory measures to protect them.

15.6 Mark Stainton, Director of Adult Social Care and Health, added that if someone refuses to engage (as is common in cases of self-neglect) the authority does not walk away from these issues and tries to find a way to work with that person, such as through the multi-agency approach where other professionals may be able to provide help. In cases of coercion and control, the authority tries to triangulate and corroborate what a person is saying by other means. This would include trying to speak to the person on their own in a safe environment away from the person who maybe be attempting to exercise control and offer them a range of opportunities to make their views known.

15.7 The Board asked if a parent wanted to keep a child indoors for cultural reasons and not access education or meet other family members, whether it would be considered to be a safeguarding issue. Alison Jeffery, Director of Children's Services, responded that yes it could be a safeguarding issue depending on the circumstances.

15.8 The Board RESOLVED to note the East Sussex Safeguarding Adults Annual report for 2022/23.

16. SUSSEX LEARNING FROM LIVES AND DEATHS (LEDER) ANNUAL REPORT 2022/23

16.1 The Board considered a report on the Sussex Learning from Lives and Deaths (LeDeR) Annual Report for 2022/23. Naomi Ellis, Director of Safeguarding and Clinical Standards at NHS Sussex introduced and gave a summary of the annual report.

16.2 Mark Stainton commented that there is an overlap between this report and the Safeguarding Adults report and the issues of mental capacity that should be considered by all practitioners. He welcomed the continued awareness raising for referrals of people who are autistic and made a request for some place-based information in future reports which would be of interest to those who operate at a place level (e.g. East Sussex, West Sussex, Brighton and Hove) such as Health and Care Boards. Naomis Ellis responded that place-based information is available and can provide it for the three areas, as well as including it in next years annual report.

16.3 Councillor Webb commented on the positive outcomes contained in the report and noted that some of the themes for improvement appear to cover things that have been an issue over a number of years.

16.4 Darrell Gale, Director of Public Health, outlined that both the LeDeR process and the National Suicide Prevention Strategy talk about people with autism, whereas the East Sussex Suicide Prevention Strategy talks about neurodivergent people which is a wider cohort of people. The LeDeR process will only pick up those people with an autism diagnosis and would not cover those people waiting for an assessment or diagnosis. The Public Health Team would like to work with the LeDeR team to ensure the same quality of data is included in the East Sussex Suicide Prevention Strategy for those people whose deaths are covered by the wider neurodivergent definition.

16.5 Naomis Ellis acknowledged that the LeDeR process uses a narrower definition and anticipated that the number of referrals in the LeDeR report for people with an autism diagnosis will probably increase, as more assessments are completed for people on waiting lists. She outlined that the LeDeR team is happy to link in with the work on suicide prevention and the Public Health Team.

16.6 The Board asked whether practitioners, when carrying out assessments, understand the diversity of capacity that people with autism and those with learning disabilities have to engage with and understand their health issues.

16.7 Naomis Ellis responded that mental capacity and the Mental Capacity Act is something that the LeDeR team need to look at through Safeguarding Adults and how it applies to transitions for 16 and 17 year olds as highlighted in the SAB Annual report. It is important that mental capacity issues are addressed for people with autism and those with learning disabilities. NHS Sussex do hold awareness weeks and bespoke training sessions for professionals to convey the diverse threshold of understanding that exists. As well as bespoke training, bite size training and specific leaflets are also available for professionals.

16.8 The Board RESOLVED to note the Sussex Learning from Lives and Deaths Annual Report 2022/23.

17. HEALTHWATCH EAST SUSSEX ANNUAL REPORT 2022-23: TOGETHER WE'RE MAKING HEALTH AND SOCIAL CARE BETTER

17.1 The Board considered a report on the Healthwatch East Sussex Annual report for 2022/23. Veronica Kirwan, Executive Director, East Sussex Community Voice introduced the report and gave a short presentation.

17.2 The Board commented on some points within the report and in particular:

- The engagement with refugees and asylum seekers, some of whom have experienced difficulties accessing medical services as they do not have English as a first language or had access to an interpreter;
- The finding that access to Child and Adolescent Mental Health Services (CAMHS) needs to be improved for children and young people; and
- Access to GP appointments and GP services continues to be a concern.

17.3 Councillor Webb asked whether there is a similar scheme in Hastings and Rother to the one in Eastbourne regarding healthcare access for asylum seekers. Veronica Kirwan confirmed that there is a similar scheme in Hastings and that Healthwatch will be conducting outreach for this service with asylum seekers.

17.4 Alison Jeffery commented that quite a lot of work is being done on the neurodiversity pathways and the services provided by CAMHS by NHS Sussex and partners. If Healthwatch is taking evidence from paediatricians, it may be helpful to talk to colleagues in NHS Sussex and for NHS Sussex to provide a briefing paper as background on the work that is already being undertaken.

17.5 The Chair commented that he will be interested to see the outcomes for the Rye Listening Tour that Healthwatch is undertaking when they become available.

17.6 The Board RESOLVED to note the Healthwatch East Sussex Annual Report for 2022/23.

18. DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT 2022/23

18.1 The Board considered a report on the Director of Public Health Annual Report 2022/23 which was introduced by Darrell Gale. The report is the last in a series of three, with a focus on loneliness and includes the work that the People Scrutiny Committee did on loneliness.

18.2 The Board thanked the Director of Public Health for a very good and detailed report. It was noted that a Notice of Motion on loneliness several years ago received unanimous Council support and how important this issue was for physical and mental health. It was also noted that some people have not been out since Covid and the impact the Covid pandemic has had on people and how this has contributed to loneliness as they avoid busy places and go out less. It was also noted that loneliness is an issue in both urban and rural communities.

18.3 Councillor Maynard thanked the Director of Public Health for a very detailed and well researched report. He commented that anecdotally there are a number of people both old and young who have not re-adjusted after Covid, and it will be important in the Council's communications activity to promote measures to encourage people, families and friends to go out more and to re-engage with their local communities. Some Parishes can be very good at tackling rural isolation and promoting local community organisations. However, the cost of living increases have also reduced social contact and are contributing to loneliness and isolation as people cut back spending on going out and socialising.

18.4 Darrell Gale summed up by commenting that the impact of Covid is really important and when communities in East Sussex had to self-isolate during Covid they did it very well, but some people have found re-adjusting after Covid difficult. Addressing people's fears about going out more will be important and there may be processes occurring that we do not yet fully understand. There may also be more work to do, for example, for people in care settings who during Covid were not allowed visitors due to strict infection control measures. This will need to be balanced against their human rights to see people and may need to be re-assessed for future pandemics.

18.5 The Board REOLVED to note the Director of Public Health Annual Report for 2022/23.

19. EAST SUSSEX SHARED DELIVERY PLAN (SDP) PROGRAMME UPDATE

19.1 The Board considered an update report on the East Sussex Shared Delivery Plan (SDP), which was introduced by Vicky Smith, Programme Director, East Sussex Health and Social Care Transformation. The report highlights the opportunities to build on the progress so far on integrated care and wellbeing in East Sussex. The report also summarises the scope of the work being undertaken and the development of Integrated Community Teams (ICTs).

19.2 Jessica Britton, Executive Managing Director East Sussex, NHS Sussex commented that a lot of the work on the SDP around the eight work streams is about the integration of teams who work with our communities and is a common thread throughout all the work. There is also a specific action to form networks in communities to tackle social isolation, which supports the work outlined in the Director of Public Health's Annual Report, particularly the recommendations around stewardship, strategy and policy. This will support a greater level connectivity within our communities and help tackle the impact of social isolation on wellbeing.

19.3 Mark Stainton outlined that there is a different format and style to the regular update which reflects the change in approach and that there is now an agreed SDP. The report sets out the agreed boundaries for the Integrated Community Teams, the integrated locality teams and the target operating model for the delivery of the Integrated Care Strategy. The Community Oversight Board in East Sussex will be the key driving force behind the delivery of the ICTs and will include representation from District and Borough Councils, the VCSE Alliance and other organisations as outlined in the governance arrangements. This is the first of the new style of reports and the next report will outline the further progress being made to improve the health and wellbeing outcomes for people in East Sussex.

19.4 The Board asked about the SDP milestone for the Children and Young People's programme plan (SDP milestone ES 5) as residents often raise issues about CAMHS and mental health services. The Board also asked for an update on the integration of budgets and how this is progressing so that they are as well integrated as possible.

19.5 Vicky Smith responded that there are a number of arrangements in place for integrated budgets such as the Better Care Fund and Section 75 arrangements which are reported to the HWB for approval. Currently, refreshed guidance on the Section 75 pooling of budgets is awaited across health and social care. It is anticipated that the guidance will set out expectations for the Integrated Care System in the future for the services that are in scope for pooling and aligning of budgets. There are also discussions being held by the Oversight Board about the delegation and aligning of budgets for services in scope at place level.

19.6 Mark Stainton added that there is £70 million in the Better Care Fund and we are awaiting guidance on the alignment of funding. However, the integration of budgets is more about how we spend the money together for the best effect. For example, it was agreed to deploy the money received for winter pressures as a system, in order to decide how best to spend the money to support services through the winter.

19.7 The Board commented that it would be interested to see how the integration of health and care across East Sussex progresses and what opportunity there would be to share or transfer learning across other areas of activity. Vicky Smith outlined that it will be possible to share learning from the Integrated Community Teams (ICTs) across Sussex through the pan Sussex ICT Delivery Board. There will be the opportunity for the cross fertilisation of ideas at Sussex and place level. Mark Stainton echoed this and added that work will include agreeing a core set of activities for all sixteen ICTs across Sussex, but there will be an opportunity for variation at place and community level to reflect the different needs of the local population.

19.8 The Board RESOLVED to:
1) Note the content of the progress report and the proposed footprints to support the development of Integrated Community Teams (ICT) in East Sussex, as described in paragraphs 2.9 – 2.12 of the report and set out in Appendix 4, and endorse their use to enable proof of concept activities to be progressed, and;
2) Note that proposals are being explored for a strengthened East Sussex 'Health, Care and Wellbeing Partnership' to reflect the broader role and involvement of Borough and District Councils, and this will be brought to a future meeting of the HWB.

20. CREATIVE HEALTH POSITION PAPER (PUBLIC HEALTH)

20.1 The Board considered a report on the Creative Health Position Paper, which was introduced by Darrell Gale. He also gave a short presentation outlining the background behind the work and the positive impacts on mental health and physiological wellbeing that art and creativity can have.

20.2 Members of the Board commented that it was a very good and interesting report and noted the beneficial impact art and creativity can have on wellbeing and loneliness. The Board also discussed the arts and community-based activities that occur across the County. The Board considered that the report should be compulsory reading for all councillors and were enthused by the work and action plan contained in the report. The Board commented that the arts can be seen as the glue that binds all parts of society and that it is countywide.

20.3 Darrell Gale outlined the expertise and passion in the Public Health Team who were behind the production of the report, which enthuses us all on how we can make the approach to creative health work.

20.4 The Board RESOLVED to:
1) Note the briefing and attached Creative Health Position Paper in appendix 1; and
2) Support the Creative Health Programmes development.

21. WORK PROGRAMME

21.1 The Board considered the future work programme of the Health and Wellbeing Board. Mark Stainton outlined that there are four items scheduled for the next meeting in December.

21.2 The Chair thanked everyone for the reports that were considered by the Board and acknowledged the huge amount of work that had gone into them and the progress that is being made as a result of all the work that is being undertaken.

21.3 The Board RESOLVED to agree the work programme.

22. ANY OTHER ITEMS PREVIOUSLY NOTIFIED UNDER AGENDA ITEM 4

22.1 There were none.

The meeting ended at 4.16 pm.

Councillor Keith Glazier (Chair)

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Report to:	**East Sussex Health and Wellbeing Board**
Date of meeting:	**12 December 2023**
By:	**Chris Robson, East Sussex Safeguarding Children Partnership Independent Chair**
Title:	**East Sussex Safeguarding Children Partnership Annual Report 2022/23**
Purpose:	**To advise Board Members of the multi-agency arrangements in place to safeguard children in East Sussex**

RECOMMENDATIONS

The Health and Wellbeing Board is recommended to receive and consider the East Sussex Safeguarding Children Partnership Annual Report for 2022-2023

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1. Background

1.1 Working Together to Safeguard Children 2018 sets out the arrangements for cooperation between organisations and agencies to improve the wellbeing of children. This places a duty on police, Integrated Care Boards and the local authority to make arrangements to work together, and with other partners locally, to safeguard and promote the welfare of all children in their area. The partnership arrangements are set out in section 4 of the report.

1.2 In order to bring transparency for children, families and all practitioners about the activity undertaken by the Children's Safeguarding Partnership, Working Together 2018 sets out that 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 child safeguarding practice reviews, and how effective these arrangements have been in practice.

1.3 The 2022/23 ESSCP Annual Report focuses on partnership evidence, learning, impact and assurance.

2. Supporting information

2.1 The ESSCP Annual Report 2022/23 (appendix 1) outlines the work undertaken by the partnership, highlighting key learning and achievements in section 2, which includes.

- 3 multi-agency Rapid Reviews conducted, of which one progressed to a Local Child Safeguarding Practice Review (LSCPR) and two LCSPRs published.
- 552 multi-agency staff attended 42 virtual training courses. 99% of evaluations rated the course as Excellent or Good, which is a further increase on last year.
- Four multi-agency audits held, which included an audit on the multi-agency response to the identification of initial need and risk, using the Joint Targeted Area Inspection (JTAI) criteria.
- Two new Lay Members recruited and introduction of 'evidencing impact' events.

- Agreed process for development of Pan Sussex training and events, plus the completion of Pan Sussex serious incident referral and rapid review procedure.
- Four additional safeguarding projects; covering neglect and poverty, transitions, information sharing with third parties and harmful sexual behaviour in education settings.

2.2 The ESSCP Annual Report 2022/23 is published on the ESSCP website, and a copy of the published report has been shared with the Child Safeguarding Practice Review Panel and the What Works Centre for Children's Social Care as per chapter 3 of Working Together 2018. A young person's accessible version of the report will also be published on the ESSCP website.

2.3 Since the writing of the annual report, the Department for Education (DfE) launched a consultation on revisions to the Working Together to Safeguard Children statutory guidance for England. The consultation aimed to gather views on updating Working Together to help deliver on the government's plans to transform children's social care set out in Stable Homes, Built on Love. In particular, the consultation focused on strengthening how safeguarding partners (local authorities, integrated care boards and the police) work together, and with relevant agencies, to safeguard and protect children locally. The ESSCP discussed the consultation at length with Board members and lead agencies and submitted a partnership response to the consultation. The revised Working Together statutory guidance is due to be published by the end of 2023.

3. Conclusion and reasons for recommendations

3.1 An effective Safeguarding Children Partnership is in place in East Sussex.

3.2 The Health and Wellbeing Board is requested to receive and consider the ESSCP Annual Report 2022/23 and to note the agreed on priorities for 2023 onwards:

- **Safeguarding children in schools** including safeguarding children who are electively home educated, excluded from school, and missing education.
- **Safeguarding adolescents** including adolescents who are criminally exploited, self-harm and/or express suicidal thoughts, child to parent abuse, and transitional safeguarding.
- **Embedding learning** and evidencing impact from case review and audit work, including ensuring that learning from the 2020-23 priority on safeguarding infants was embedded.

CHRIS ROBSON

Independent Chair,

East Sussex Safeguarding Children Partnership

East Sussex Safeguarding Children Partnership

Annual Report 2022/23

Contents

Foreword

Thank you for taking the time to read the East Sussex Safeguarding Childrens Partnership (ESSCP) Annual Report. This document should give you an open, honest view of how the Partnership works to safeguard our children and young people. As the Independent Chair and Scrutineer of the ESSCP I have the responsibility for scrutinising this report and making sure it is accurate and provides the information you, the reader, requires. I hope that it meets your expectations and above all gives you complete confidence in the way the Partnership strives to safeguard children in East Sussex.

I wanted to start by offering some reassurance regarding the strength of the Partnership. During the reporting period covered by this document I have observed some truly outstanding partnership work. The safeguarding culture in East Sussex affords everyone the opportunity to be confident that they will be supported as they strive to improve outcomes for our children and families. That culture permeates from the very top of the organisations through to the practitioners whom we so heavily rely on. I meet with those at executive level, and I am consistently impressed with their commitment to safeguarding, personal investment and leadership. Representation at Partnership meetings is excellent and there is a culture of support and challenge as we strive to reach our joint objectives. Perhaps of greatest importance is the fact that East Sussex is blessed with a professional, caring and incredibly hard-working community of individuals who work and volunteer in the safeguarding arena. On behalf of the Partnership, I would like to offer each of them our sincere thanks for all they do.

This report sets out our achievements, concentrating in part, on the areas we have prioritised. Whilst it is right that we celebrate success it is also important that we recognise that we should always seek to improve. I have seen a real will to seek continuous improvement in East Sussex, the training offer is excellent, supported by effective trainers from a wide range of backgrounds. The response to learning reviews is effective and all partners are alive to disseminating lessons learned at the earliest opportunity. Please spend some time reading the sections of this report that details some of these reviews. They touch on some of the most distressing cases our practitioners, communities and families are involved in. They also offer some of the best opportunities for us to learn and improve outcomes for children.

I would also like to take a moment to acknowledge the fantastic work of the ESSCP business support team. They work tirelessly behind the scenes to make sure that our business runs smoothly, and I would like to thank them on behalf of all the partners.

Finally, when you read this report, I would ask that you consider the impact you can have. Safeguarding children is the responsibility of all of us, professionals, volunteers, families, friends, and communities. Please don't be afraid to raise concerns, seek advice or offer to help.

Chris Robson

Independent Chair of the East Sussex Safeguarding Children Partnership

1. Introduction

Welcome to the 2023 annual report, on behalf of the three statutory partners, thank you for taking the time to read this and for your support in our continuing progress to improve how we work together to deliver the best possible services to our communities.

We hope you find the report useful in understanding the partnership's work and celebrating some of the successes. These successes are only possible through the dedication and diligence of the many people working with children, young people and families across a range of agencies.

We continue to keep children at the centre of our thinking and delivery at all levels, as well as encouraging professional curiosity across the multi-agency workforce, ensuring the lived experience of the child is recognised.

We are continuously learning with over 500 staff trained across the learning programme and many more accessing learning through briefings, online learning and multi-agency meetings. We know from our quality assurance that our services make a positive difference to the lives of many children, young people and families every day. We do not always get everything right. Serious incidents when they occur are, of course, the subject of Rapid Reviews and Local Child Safeguarding Practice Reviews. We are pleased to see the high quality of those reviews and the partnership embracing any learning in a timely way. Our learning doesn't stop there, from the task and finish groups to the case file audits to lively discussion, the culture is of working together, learning together and delivering together which is a positive indicator for the partnership potential for the coming years.

Thank you again for your ongoing support, your hard work and commitment to this vital area of work to improve the lives of our children and their families in East Sussex.

Naomi Ellis

Director of Safeguarding & Clinical Standards, NHS Sussex

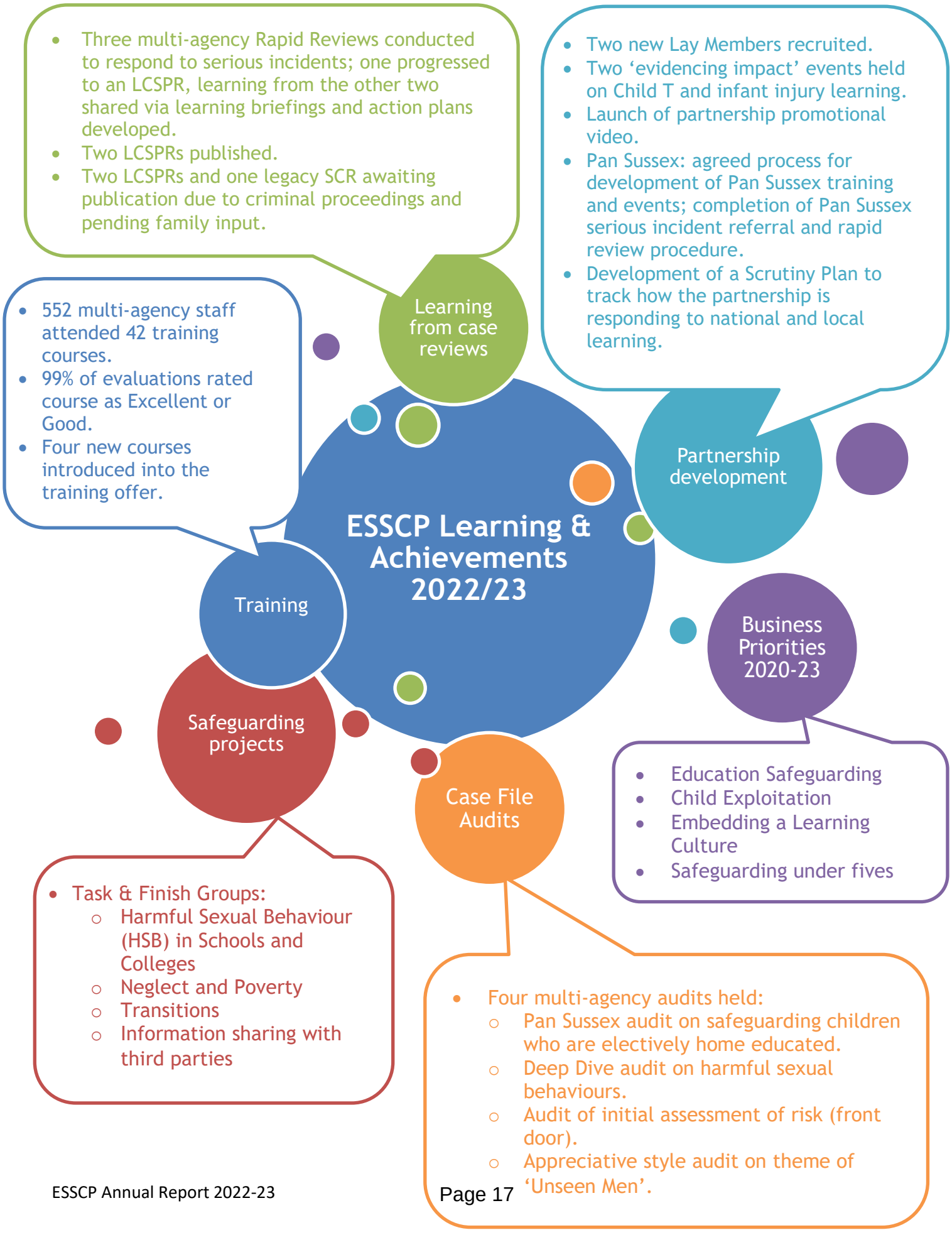
Alison Jeffery

Director of Children's Services, East Sussex County Council

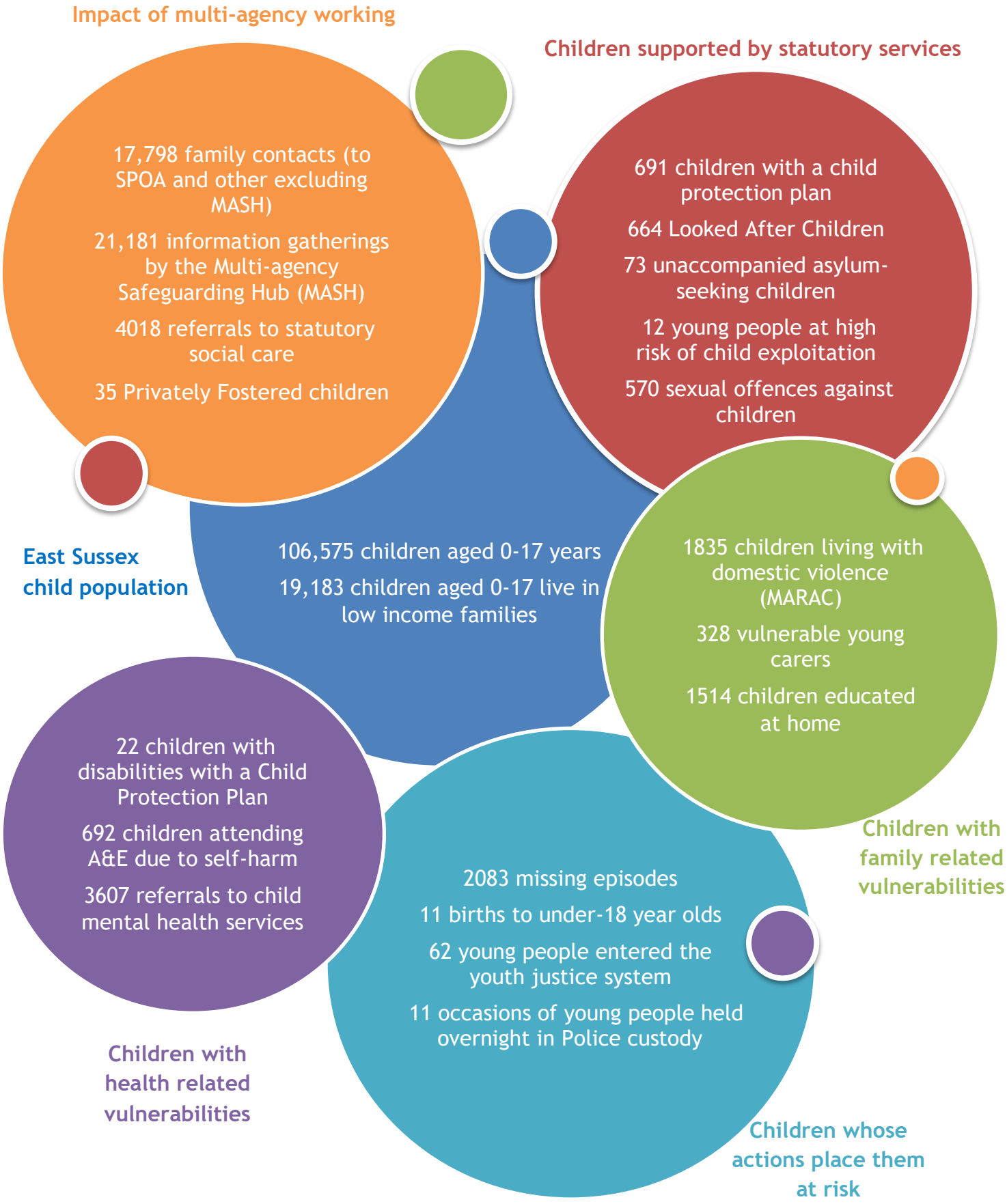
James Collis

Chief Superintendent, Head of Public Protection, Sussex Police

2. Key Learning & Achievements 2022/23



3. Safeguarding Context 2022/23



See **Appendix A** for more detailed information.

4. Partnership Arrangements

4.1 Overview of the Partnership

The East Sussex Safeguarding Children Partnership acts as a forum for the lead safeguarding partners (Sussex Police, East Sussex County Council, and the NHS Sussex) to:

- agree on ways to coordinate safeguarding services in (the geographical local authority borders of) East Sussex.
- act as a strategic leadership group in supporting and engaging other agencies across East Sussex; and
- implement local, regional, and national learning, including from serious child safeguarding incidents.

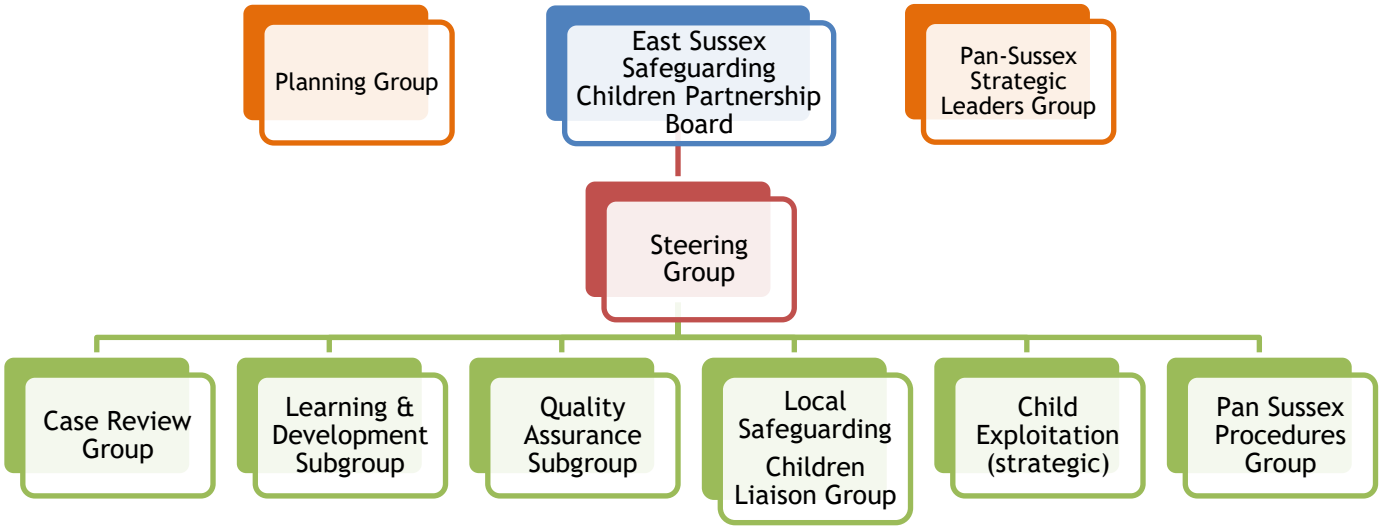
4.2 Partnership Structure and Subgroups

The Board is chaired by an Independent Chair, meets four times a year and is made up of the statutory safeguarding partners and relevant agencies (full list of board members is included in Appendix B). The Independent Chair also chairs the ESSCP Steering Group which meets four times a year. The Independent Chair fulfils the role of the Independent Scrutineer and acts as a constructive critical friend to promote reflection to drive continuous improvement.

The main Board is supported by a range of subgroups that lead on areas of ESSCP business and are crucial in ensuring that the Partnership's priorities are delivered. These groups ensure that the Partnership really makes a difference to local practice and to the outcomes for children and young people. Each subgroup has a clear remit and a transparent mechanism for reporting to the ESSCP, and each subgroup's terms of reference and membership are reviewed annually.

The three ESSCP safeguarding leads and the Independent Chair form the Planning Group, which also meets quarterly. The Planning Group discusses and agrees the short-term agenda for the work of the partnership and addresses any emerging safeguarding issues requiring strategic input. It also agrees the budget for the ESSCP (see Appendix C).

The Pan-Sussex Strategic Leaders Group membership consists of lead safeguarding partners across East Sussex, West Sussex, and Brighton & Hove. The group's purpose is to focus on setting the 'road map' for future partnership development and identify shared safeguarding priorities and opportunities across the three areas.



Terms of Reference for the Board and Steering Group are available on the ESSCP's website here: Subgroups - ESSCP

4.3 Links to Other Partnerships

The Partnership has formal links with other East Sussex and Pan-Sussex strategic partnerships, namely the Health and Wellbeing Board; Pan Sussex Child Death Overview Panel (CDOP), Safeguarding Adults Board (SAB); Safer Communities Partnership; West Sussex and Brighton & Hove Safeguarding Children Partnerships; the Sussex Integrated Care System Children and Young People's Board, Children and Young People Trust (CYPT) and Local Head Teacher Forums. Links to other significant partnership documents are highlighted in Appendix D.

The ESSCP Independent Chair is also the Independent Scrutineer for the West Sussex and Brighton & Hove Safeguarding Children Boards which will enable and facilitate greater joint working between the three areas. The Chair also maintains regular liaison with other key strategic leaders, for example, the Police and Crime Commissioner, Adult Partnership Chairs and Government inspection bodies. The ESSCP annual report is presented to the East Sussex County Council People Scrutiny Committee and Health and Wellbeing Board, and the East Sussex SAB. The report is also shared with the Safer Communities Board, the Police and Crime Commissioner and other ESSCP member organisations' senior management boards.

At the end of March 2023, the ESSCP had the opportunity to undertake an exciting and effective piece of joint working with the Safer East Sussex Team, who had secured Home Office funding for Shout Out UK to deliver 3 large scale events on *'Preventing online Radicalisation'*. The East Sussex Prevent Board was responding to an increasing in casework that involves extremism with an online element, such as accessing extremist material on websites and forums, and making contact with others on encrypted and gaming platforms. These events, that complemented the ESSCP training programme, took place in venues across East Sussex and were well attended. An evaluation report for these events will be available during either Quarter 1 or Quarter 2 of the 2023/24 reporting period.

Joint training on Coercion and Control is now embedded in the ESSCP Training Programme and a multi-agency Domestic Abuse Task and Finish Group continues to update the existing Domestic Abuse (DA) Training Pathway. This is in recognition of the Domestic Abuse Act 2021 and because partnerships continue to see similar DA conclusions and recommendations from Safeguarding Adult and Children Reviews, Domestic Homicide Reviews, and referrals to the LADO. The refreshed pathway is designed to reflect key emerging issues. From April 2022 the DA Training offer has expanded due to increased involvement from the Domestic Abuse, Sexual Violence and Abuse & Violence against Women & Girls (VAWG) Joint Unit, Brighton & Hove and East Sussex.

4.4 Pan Sussex Working

Although the ESSCP's focus is on safeguarding children in East Sussex, it should be expected that child protection and safeguarding procedure continue to be developed at a Pan Sussex level, and opportunities for joined up working across Sussex will be promoted where appropriate. Examples of Pan Sussex working in 2022/23 include:

- **Pan-Sussex Learning & Development** opportunities:
    - Considerable work has been undertaken to develop learning at a Pan Sussex level, and opportunities for joined up working across Sussex are promoted where appropriate. During 2022/23 Pan Sussex training continued with: *Multi-Agency Public Protection Arrangement (MAPPA), Improving Outcomes for Looked After Children* and *Harmful Practices*. New *Suicide Prevention* courses ran as a Pan Sussex offer via Grassroots, an external provider.
    - Through continuing collaborative working with training counterparts in Brighton and Hove and West Sussex the SCPs are now offering new training on '*Adultification*'. The in-house training on *Working with LGBTQ Children and Young People* is now offered pan-Sussex. The three SCP's continue to review further opportunities for joint delivery of courses where practical and beneficial for all 3 Safeguarding Children Partnerships.
- **The Pan-Sussex procedures working group** reviews, updates and develops over 100 safeguarding and child protection policies and procedures in response to local and national issues, changes in legislation, practice developments and learning from LCSPRs and quality assurance activities. There is excellent attendance and buy in from all lead agencies and Pan-Sussex Local Authorities. Since March 2022 a number of new policies have been published. These include:
    - A procedure to describe the sharing of information between Police and the LADO
    - A statement about Professional Difference has been added to a number of relevant policies
    - A procedure on how to respond to a suspected suicide
    - A Sussex Safeguarding Children Partnership Anti Racist Statement
    - A procedure on sharing information with family members about other adults and the risks they may pose

  There has also been some significant re-drafting of existing policies and procedures. This includes:

- A review of Allegations against people who Work/Volunteer with Children, which was updated to align with Keeping Children Safe in Education 2021 updates
- A review of the Online Safety Policy to include the Dark Web, safeguarding children with SEND online, online bullying and the impacts of harmful content in relation to self-harm, suicide and eating disorders
- The inclusion of virginity testing and hymenoplasty to the Honour base abuse policy
- An extensive review and re-draft of the policy regarding parent carer involvement in sex work

After each meeting, a short briefing is disseminated to the Group for onward cascading across their agencies to front line professionals and these can be read online Welcome to your Pan Sussex Child Protection and Safeguarding Procedures Manual | Sussex Child Protection and Safeguarding Procedures Manual. Going forward, the aim is to improve the intuitive user experience of searching for Policies on the website and further work to understand website use and how people engage with the policies.

- **Pan-Sussex Child Safeguarding Practice Reviews Procedure** – in March 2023 the new Pan-Sussex procedure for referring a serious incident to Case Review Group and the process for undertaking a Rapid Review and Local Child Safeguarding Practice Review was published. This joint procedure allows the three partnerships to have the same templates and approach which is beneficial to agencies working across the Pan-Sussex area. It also incorporates best practice from the National Panel with regards to undertaking effective reviews.

4.5 Ongoing review of Partnership Arrangements

Lead Safeguarding Partners Self-Assessment

Every other year, lead safeguarding partners undertake a self-assessment as part of the activity to review the effectiveness of local partnership arrangements. At the end of 2020/21 the lead partners used the *'six steps for independent scrutiny of safeguarding children partnership arrangements'* developed by the University of Bedfordshire. For 2021/22 a Partnership Development Action Plan was created to address the areas rated as red/amber, in particular regarding *'involving children, young people and families in plans for safeguarding children'*. Progress on this action plan was reported on in last year's Annual Report.

During the first half of 2023/24 lead partners will be using the National Safeguarding Panel's 'reflective questions for safeguarding partners', as set out in their 2021 Annual Report, to assess the effectiveness of local partnership arrangements. The reflective questions draw on what the National Panel has identified are factors behind effective and strong child protection practice. The questions are framed around 4 areas: wider service context; practice and practice knowledge; systems and processes; and leadership and culture.

Areas for improvement will be highlighted in the Partnership's development action plan, with progress reported on in next year's Annual Report.

Review of arrangements with Board and Partnership Members

At the end of 2022/23 the ESSCP Business Unit sent a questionnaire to all board and subgroup members to consider the effectiveness of current partnership arrangements.

In total, 17 partnership members responded. Feedback was largely positive with reassuring responses to the quality of the administration, and the communication of the partnership. The majority of partnership members were clear about their role and the support they received to fulfil their role. Nearly all partnership members were confident about communicating what the partnership does and what the priorities of the ESSCP were.

Most encouraging was the reported impact of the partnership on safeguarding and child protection practice. Over 80% of partners responded that partnership learning impacts on the work they do; nearly two-thirds had discussed one of the ESSCP learning briefings in their team meetings, and a similar proportion agreed that ESSCP learning had changed the way their team works.

The survey has been useful to the ESSCP business unit to identify future improvements and planning of meetings. Suggestions include:

- ✓ Updating the Induction Pack and sending out to all members on an annual basis.
- ✓ Considering how to incorporate a stronger focus on 'holding up a mirror' to local practice and the experience of children and families.
- ✓ Following up on past board agenda items, including links to published documents (post discussion of draft versions at board meetings).
- ✓ Better sharing of actions and information across the partnership groups.
- ✓ Considering the implementation of an 'education' subgroup to ensure appropriate engagement of schools and other education providers.

4.6 ESSCP Priorities

Following the formation of the ESSCP in September 2019, discussions took place to determine our priority areas of focus for 2020 to 2023. The partnership felt strongly that priorities should relate to key areas of child safeguarding; those identified as of highest risk in the county, where multi-agency working is essential and where significant change and/or commitment is necessary to reduce risk. Priority development took place with both the Steering Group and Board and were agreed by the three safeguarding partners in May 2020. More information on the priorities is contained in the impact and evidence sections of this report. The agreed ESSCP Priorities for 2020-2023 were:

- **Safeguarding in Education**
- **Child Exploitation**
- **Embedding a Learning Culture**
- **Safeguarding under 5s**

It was considered that ensuring the voice of the child, and taking a contextual safeguarding approach, would be cross cutting over all the ESSCP priorities.

In March 2023 the ESSCP held an extraordinary Board meeting to discuss local evidence – including learning from case reviews, quality assurance activity, and the voice of children – and propose future priorities for the partnership. Proposed priorities were scoped which clearly

identified the evidence to choosing as a priority, the intended impact on practice and outcomes for children, and how success would be evidenced. From the priorities proposed, the safeguarding leads agreed on the following priorities for 2023 onwards:

- **Safeguarding children in schools** including safeguarding children who are electively home educated, excluded from school, and missing education.
- **Safeguarding adolescents** including adolescents who are criminally exploited, self-harm and/or express suicidal thoughts, child to parent abuse, and transitional safeguarding.
- **Embedding learning** and evidencing impact from case review and audit work, including ensuring that learning from the 2020-23 priority on safeguarding infants was embedded.

5. Evidence

This section of the ESSCP Annual Report sets out how the partnership is using evidence to determine its priorities; shape the way multi-agency partners have taken actions or adopted specific practice models; and evaluate the impact of partnership work. Examples of how the partnership are evidencing the impact of its work are also given in section 3 (Impact).

ESSCP priorities for 2020-23 were chosen because they were identified as of highest risk in the county, where multi-agency working is essential and where significant change and/or commitment was necessary to reduce risk. It is in such areas where the partnership can be most effective in scrutinising and supporting practice.

5.1 Safeguarding in Education

Why is safeguarding in education a priority?

Everyone who encounters children, and their families, has a role to play in safeguarding children. Early years, school and college staff are particularly important as they see children daily and can identify concerns early and provide help for children, to prevent concerns from escalating. Education settings, and their staff, form a key part of the wider safeguarding system for children.

The ESSCP agreed that by making this area a priority for 2020-2023, there would be a continued focus on effective joint working between local agencies and education settings, strategically and at a setting level. The COVID-19 pandemic and extended school closures for most children highlighted to many services the critical importance of education settings' role in safeguarding. Given the ongoing impact of the pandemic on safeguarding issues, and wellbeing of children, in March 2023 the ESSCP agreed that 'safeguarding in education' would continue to be a priority for the partnership going forward.

Using evidence to deliver safeguarding in education

The Education Safeguarding agenda has significantly altered as a result of COVID-19 national lockdowns with safeguarding, alongside emotional wellbeing, now a higher priority within all local education settings. Most education settings report that new safeguarding issues for different groups of children have emerged; these include higher incidences of children witnessing domestic abuse, demonstrating harmful sexual behaviour, and experiencing mental health issues. Improving school attendance in order to safeguard children is a priority both nationally and locally. Examples of using local and national evidence in 2022/23 has included:

- The revised Harmful Sexual Behaviours Protocol for schools was launched in January 2023. The protocol provides detailed local guidance on how schools should respond to incidents of child on child sexual harassment, sexual violence, or harmful sexual behaviour (HSB). The protocol was updated in collaboration with a range of multi-agency partners via the ESSCP HSB Task & Finish Group. The revised protocol also includes a new East Sussex screening tool. The HSB data was collected for the first time in 2022, which was used to reinforce targeted work with primary schools and to develop an intervention programme for children who have displayed HSB.

- The revised Vulnerable Learners Protocol was finalised and shared with schools and colleges in May 2022. The revisions were made in response to learning from the Thematic Local Child Safeguarding Practice Review.
- A new 2-year cycle of safeguarding reviews has been established with all maintained schools in East Sussex. A new QA review process has also been established with Independent non-maintained special schools and a commissioning process are in place to conduct reviews of Multi-Academy Trusts. More comprehensive monitoring of standards of safeguarding in all schools and colleges, via these new processes, will allow the education safeguarding team to tailor training according to needs, and to provide support to improve practice where safeguarding requires improvement.
- The Mental Health Support Teams in schools supported 800 children last academic year with 1:1 and small group interventions. Outcomes are broadly positive, and the data collected is now being used to inform county wide 'whole school approach' work to support children's wellbeing.

Evidence to measure success (2022-23)

- ✓ **The proportion of schools who complete their annual s175/157 safeguarding audit.**

  100% of state funded schools completed the annual section 175 audit this year.

- ✓ **The proportion of secondary and special schools that participate in the multi-agency project on County Lines and Harmful Sexual Behaviour and evaluation data on impact.**

  23 secondary schools and 4 special schools received the performance 'Safe and Sound' a preventative approach to tackling violence against women and girls. 5100 students participated and all student evaluations were positive and felt the package increased their knowledge and understanding of healthy and unhealthy relationships.

5.2 Child Exploitation

Why is child exploitation a priority?

Child Exploitation occurs where an individual or group takes advantage of an imbalance of power to coerce, control, manipulate or deceive a child or young person under the age of 18 into any criminal activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial or other advantage of the perpetrator or facilitator and/or (c) through violence or threat of violence. The victim may have been criminally exploited even if the activity appears consensual.

'County lines' is a form of criminal exploitation. It is a police term for urban gangs supplying drugs to suburban areas, and market and coastal towns, using dedicated mobile phone lines or 'deal lines'. It involves child criminal exploitation (CCE) as gangs use children and vulnerable people to move drugs and money.

East Sussex Safeguarding Children Partnership has a strategic focus on child exploitation due to the geographical location of East Sussex, its transport links with London and the mix of rural and city conurbations.

Using evidence to tackle child exploitation in East Sussex

The Multi-Agency Child Exploitation Group (MACE) action plan is annually refreshed and focuses on four areas:

- **PREVENT** – delivering evidenced based preventative interventions within schools and communities to equip children and families with the skills they need to make safe and healthy choices and avoid situations which put them at risk of child exploitation.
- **PREPARE** – deliver a holistic and effective response to children and young people referred to the Safeguarding Adolescents From Exploitation and Risk (SAFER) panel, that reflects learning from previous LCSPRs, case audits, and user feedback.
- **PROTECT** – strengthen support and safeguarding arrangements for those young people who are reported missing or are referred to SAFER.
- **PURSUE** – deliver 'disruption measures' to divert children and young people away from being exploited and stop those engaging in child exploitation.

Examples of using local and national evidence in 2022/23 has included:

- Delivery of a whole school programme, funded by drug prevention monies and delivered in partnership with schools by the education safeguarding team, Public Health and CSD. A comprehensive evaluation of the project is available to the Partnership including the request to consider sources of future funding.
- Implementing changes to practice following the Child AA LCSPR including sharing of disruption activity from the Serious Organised Crime Unit, development of new Inclusion Partnerships to discuss vulnerable children, and new head of service appointed for LD and Transitions.
- Evolution of MACE to SAFER Panels, which has incorporated MACE and VARP (vulnerable adolescent risk panel) into a combined meeting. The introduction of these operational changes has enabled improved referral quality and meeting capacity as well as improvements to agency interface.
- Contextual safeguarding responses have focussed upon Eastbourne Train Station in 22/23 and risks specific to County Lines.
- The area of performance which remains concerning to the MACE strategic group is that of missing children. Episodes of reported missing has significantly increased in 22/23 and remains an area of improvement for those agencies involved in the delivery of responses. An improvement plan has been developed by social care and performance is being closely monitored by the group.
- A Sussex force wide intelligence policy has recently been launched and that combines the ES Intel protocol with a Pan Sussex operating framework. NHS and Police strategic leads are working together to ensure effective embed of the intel sharing practice into the NHS critical care setting.
- The intended review of disruption tactics and application of legal measures is still pending although an increase in the disruption measures deployed at a MACE operational level continues to increase (60% at January 2023).

Evidence to measure success

- ✓ At the end of March 2023 there were **22 children, at risk of exploitation**, who were held within the 'SAFER' process. Over the course of 2022/23, on average, MACE/SAFER has had an active case load of 24, with highs of 27-29 in November, December and January.
- ✓ Over the course of the 2022/23, 11 children have had their concern rating increase from amber to red, and **21 children have had their concern rating decrease**. However, this often demonstrates an increase in the information available regarding a child which then enables professionals to have a more informed picture of their exploitation.
- ✓ Nearly half (45%) of the current cohort of children held by SAFER is six months or less. Of the current cohort, 8 children have been with SAFER for a year or more. Of those who are no longer held by SAFER, the average time for a child to be assessed as at lower risk, following intervention, was 5.3 months.
- ✓ In 2022/23 there were **11 incidences of young people held overnight in police custody.** This is much lower compared to 26 incidences in 2020/21. The reduction in incidences of young people held overnight in police custody is due to the robust approach taken by Police across custody centres and the Force to drive down to an absolute minimum the number of children who need to remain in custody overnight. Police are achieving this through prioritising investigations involving children, working closely with partners to secure accommodation where required and using bail with conditions more effectively.

5.3 Embedding a learning culture

Why is embedding a learning culture a priority?

The ESSCP is committed to creating and strengthening a learning culture across all agencies in East Sussex who work with children and young people. A culture which is open, and able to challenge all partner agencies, will be able to identify learning, improve, and then evaluate effectiveness. The ESSCP agreed to make 'embedding a learning culture' a priority to ensure that the partnership becomes better focused on learning with the following three aims:

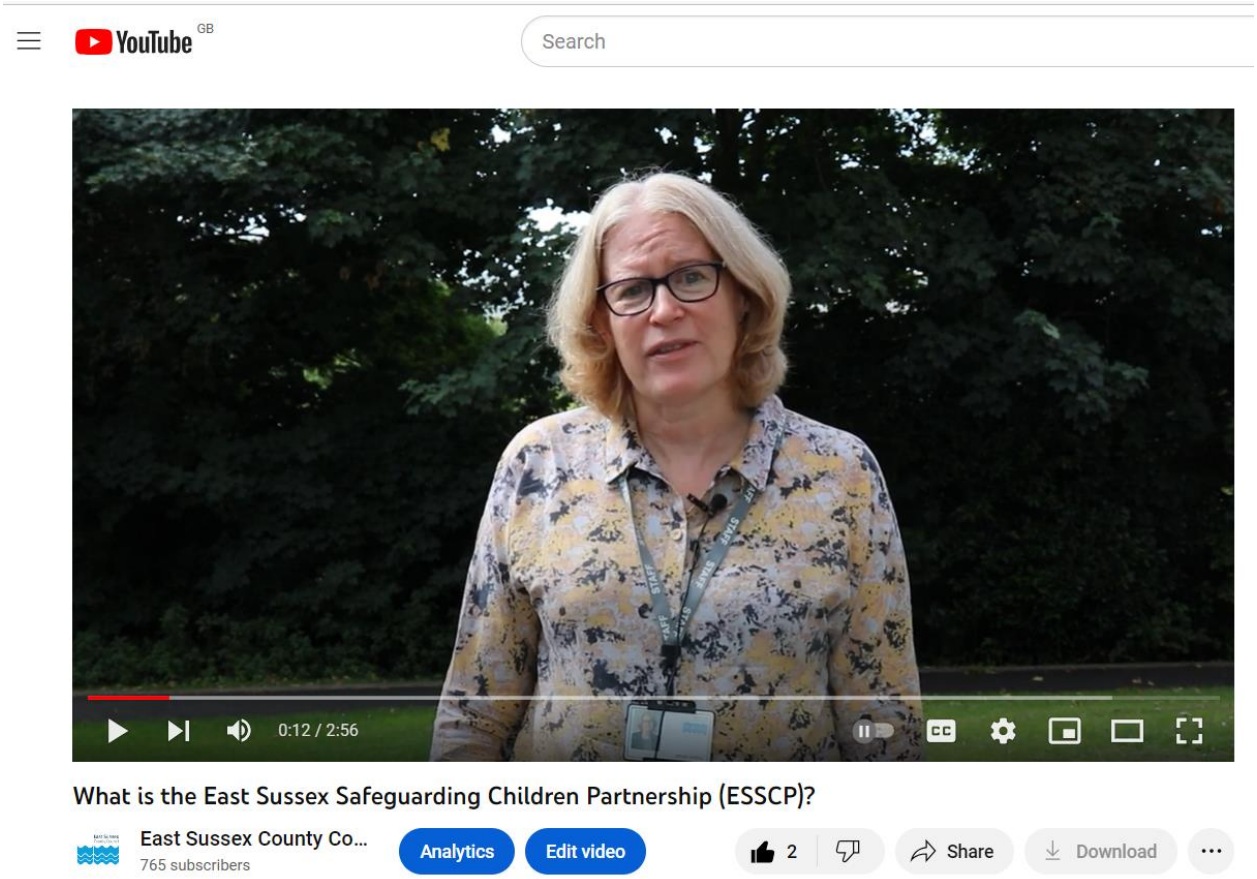
- the learning reaches the right people.
- we have effective mechanisms for sharing learning.
- and we test that learning is embedding into practice and outcomes for children.

Using evidence to embed a learning culture in East Sussex

The arrangements for assuring the effectiveness of safeguarding practice are set out in the **ESSCP's Learning & Improvement Framework.** Examples of using local and national evidence in 2022/23 has included:

- Holding two 'evidencing impact' events – with one event focusing on the impact of learning arising from the Child T Serious Case Review (published in 2019) and a themed event on 'infant injuries', which considered the impact of learning arising from the Child V and Child W Serious Case Reviews (conducted in 2019) and three rapid reviews, which were conducted in 2020 following serious incidents involving non-accidental injuries to babies, occurring in the first national COVID-19 lockdown. The impact of the events on practice and outcomes for children and families is shown in report section 7.

- Delivering four ‘learning from Review’ briefing sessions for staff in July 2022, December 2022, and January 2023. In total, over 200 staff attended these four separate events.
- In March 2023 the Partnership Board held a ‘priority setting’ workshop to review local evidence. Evidence included data and learning from recent LCSPRs and rapid reviews, learning from recent case audits, results of the 2022 section 11 self-assessment, safeguarding performance data, and the voice of children and young people. Future priorities were developed based on available evidence.
- The QA subgroup held an ‘appreciative style’ audit on the engagement of fathers and other male carers in safeguarding work. Eight cases were selected where either the father/male posed a risk to the child and successful engagement by services reduced that risk and/or they were successfully engaged to ensure the child was protected/nurtured. Key learning from the audit will be shared via a learning briefing and series of lunchtime training sessions in autumn 2023.
- The ESSCP published a three-minute video explaining the purpose of partnership and its work. The aim of the video is if everyone who works with children and families knows about the Partnership, this will increase the likelihood of them reading one of the ESSCP’s learning publications and keep up to date with local learning and practice developments. The video will be embedded into induction processes for new staff and initial safeguarding training across the children’s workforce.



Evidence to measure success

- ✓ Front line staff and leaders/managers in every agency to know what the ESSCP is and can recall learning themes from recent learning briefings.

- ✓ Front line staff to feel confident in how to respond if they have a safeguarding concern.
- ✓ Staff to know where to look for more information/resources on safeguarding themes.

5.4 Safeguarding under 5s

Why is safeguarding under 5s a priority?

Local and national learning tells us that babies and young children are particularly vulnerable to abuse and neglect. Following on from two local serious case reviews involving babies and young children, the ESSCP decided to focus on 'safeguarding Under 5s, as one of its key priorities, to ensure that action arising from the reviews was coordinated and the profile of safeguarding under 5s was raised across partner agencies.

Nationally, babies under 12 months old continue to be the most prevalent group notified to the national safeguarding panel following serious incidences, with around 40% of serious case reviews involving children aged under 1. There were also a high proportion of cases involving non-accidental injury and sudden unexpected infant death. In these cases, parental and family stressors were the most significant factor in escalating risk. In the first few months of the 2020 Covid lockdown the ESSCP also completed three rapid reviews following serious safeguarding incidents involving non-accidental injuries involving children under the age of one. Learning arising from these reviews was compiled in a learning briefing for professionals and a combined action plan produced, which has informed ongoing work in this priority area, and is monitored regularly by the ESSCP Case Review Group and Steering Group.

Learning from the Pan Sussex Child Death Overview Panel has also highlighted the need for a multi-agency response to the number of incidences of sudden and unexplained infant deaths where modifiable factors were identified.

Using evidence to safeguard children under 5 in East Sussex

The 'Safeguarding Under 5s' action plan is jointly owned by the Designated Nurse for Safeguarding in NHS Sussex and the Children's Lead in East Sussex Public Health. The leads were supported by a short-life Task and Finish Group to drive ahead action in this area, which ended in 2022. During 2022/23 examples of using local and national evidence has included:

- Embedding of ICON (infant crying is normal) across multi-agency partners to prevent abusive head trauma. Direct training sessions have been delivered to different groups of professionals, including GPs, midwifery, Sussex Police, health visitors, early help, and children's social care.
- Launch of a social media toolkit to raise awareness amongst professionals, and the general public, to reduce and prevent childhood unintentional injuries, highlighting how many accidents can be prevented with the right knowledge. The Child Accident Prevention Trust (CAPT) training for professionals that ended in 2022 was evaluated, showing an increase in knowledge, understanding and skills across all elements of the training. This included understanding of hazards, raising issues with parents/carers, and knowledge of resources and equipment available.
- East Sussex County Council Public Health has commissioned University College London (UCL) Centre for Behaviour Change to support our local knowledge, skills, and confidence

in applying behavioural science using the Behaviour Change Wheel (BCW) to preventing unintentional childhood injuries. The BCW can be used to help to develop behaviour change interventions from scratch, build on or modify existing interventions or choose from existing or planned interventions. A Task & Finish group has been established to develop this project during the next 2023-24 financial year.

- During 2022-23 the SCP Partnership has focused on refreshing professionals' advice (including Sussex wide webinars) on evidence-based scientific recommendations to be followed for all the baby's sleep periods (not just at night). Recent SUID deaths before Christmas, however, highlight the need to continue work in this area, embedding good practice and the recommendations from the National Safeguarding Panel's Out of Routine report.
- Although the ESSCP has not made 'safeguarding under 5s' a priority for 2023, ensuring that learning from this priority, and learning from national reports such as Out of Routine and Myth of Invisible Men, will be included in the 'embedding learning' priority.

Evidence to measure success

- ✓ There have been **no child deaths across Sussex involving abusive head trauma (AHT)**, over the past three years. This follows three suspected AHT in 2019/20.
- ✓ The number of **children aged 0-4 attending East Sussex hospital A&Es due to accidents has decreased** from 2,803 in 2021/22 to 2752 in 2022/23. Poisonings accounted for 127 of those attendances; falls from furniture accounted for 471 attendances.

6. Learning

The ESSCP is committed to creating and strengthening a learning culture across all agencies in East Sussex who work with children and young people. A culture which is open, and able to challenge all partner agencies, will be able to identify learning, improve, and then evaluate effectiveness.

Below are examples of 'learning' within and across the ESSCP in 2022/23.

6.1 Learning from Rapid Reviews and Serious Case Reviews

Case Review Activity 2022/23

In 2022/23 the ESSCP undertook three Rapid Reviews following serious safeguarding incidents, where a child had died or been seriously injured, and where abuse or neglect is known or suspected. Of the three rapid reviews undertaken:

- ✓ One progressed to a joint LCSPR and Domestic Homicide Review (DHR) (Family D);
- ✓ Two did not lead to a LCSPR. In these cases learning was shared via learning briefings and individual agency actions from rapid reviews monitored by CRG

One outstanding SCR – Child V (Infant injuries) is due to be published following completion of criminal procedures and once parent input into the review has been gained (expected June 2023).

During 2022/23 the ESSCP published two LCSPRs:

Child AA – published September 2022	Thematic Review – published September 2022
Child AA Learning Briefing 2022 (esscp.org.uk) *Child AA LCSPR Sept 22* *Child AA Partnership Response Sept 22* **Key learning:** ✓ Multi-agency activity to disrupt criminal exploitation ✓ The impact of missing education - poor attendance as a risk factor to criminal exploitation ✓ Transition between educational establishments for children who are excluded from school ✓ Information sharing between educational establishments, and between schools and other agencies	*Thematic Review Learning Briefing 2022* *Thematic Review Sept 22* *Thematic Review Partnership Response Sept 22* **Key learning:** ✓ Knowing and considering a parent's history and vulnerabilities ✓ Working with hard to engage families who refuse to cooperate with child protection planning ✓ Recognising where there is no further police investigation of an issue, this does not mean that a child is not at risk.

✓ Understanding that behaviour is communication - using a 'therapeutic thinking' approach to address trauma-based behaviours	✓ The impact on children of reoccurring domestic abuse and parental mental health issues ✓ Vulnerable children approaching adulthood and the impact of COVID-19

Two LCSPRs are awaiting publication:

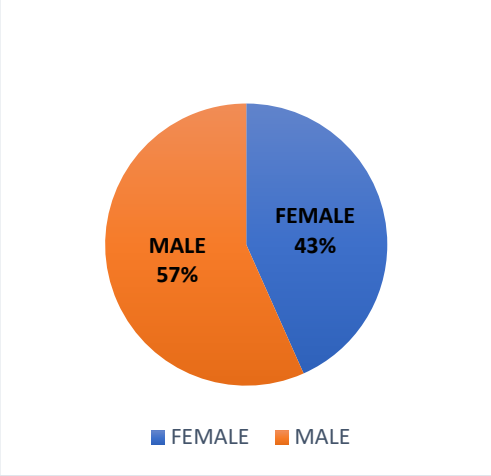
Child Z (delay in publication due to ongoing criminal proceedings – Trial expected December 2023) *Child Z Learning Briefing 2022 (esscp.org.uk)* **Key learning:** ✓ The legacy of relationships characterised by domestic abuse ✓ Information sharing about adults who may pose risks to children ✓ The importance of assessing background information ✓ Assessing risk to children from risky adults who are not household members, but part of the child's wider network	**Family CC** (due to be published shortly once family have had the opportunity to contribute) *Family CC and Neglect Learning Briefing (esscp.org.uk)* *This briefing also reflects on learning from rapid reviews, featuring significant neglect* **Key learning:** ✓ Working with 'highly resistant' parents ✓ Safeguarding children who are EHE in the context of neglectful parenting ✓ Relevance of neglect and/or abuse of animals when assessing risks to children ✓ Relevance of history when screening for service delivery ✓ Role of voluntary sector agencies in providing support to vulnerable families ✓ The cumulative risk of harm when risk factors are present in combination or over time

Rapid Review learning

Child 1 **Key learning:** ✓ Suitable access by children aged 14-16 who are being electively home educated to education at institutions whose primary purpose is post 16 education and training.	**Child 2** **Key learning:** ✓ Consideration of parents mental and physical health needs and the impact this has on the ability to effectively parent.

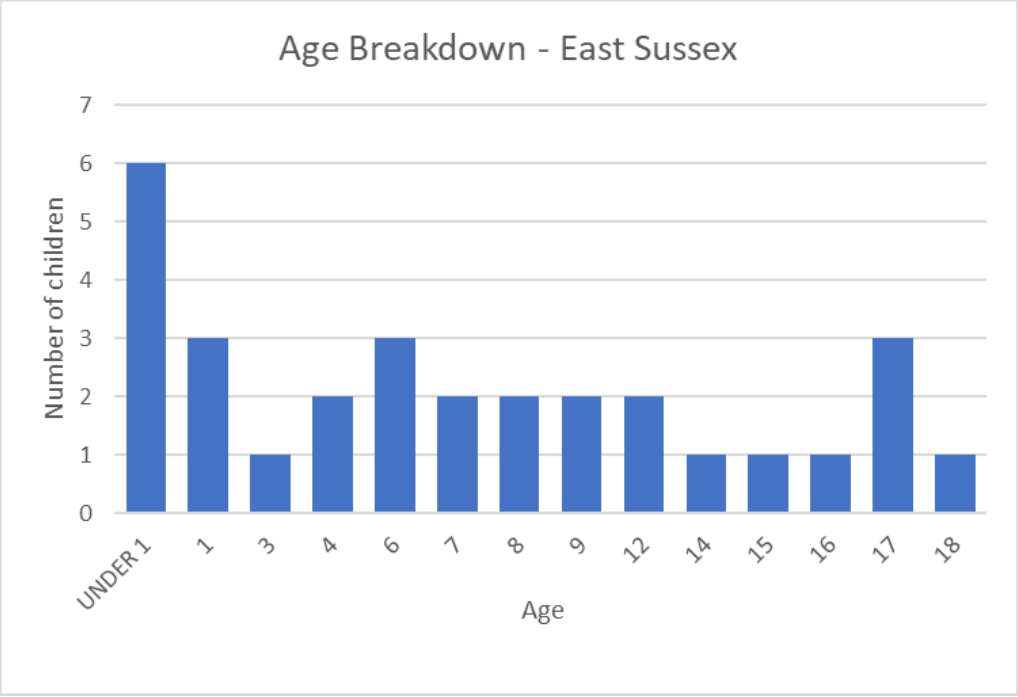
✓ Support offered by services to children and families following unsuccessful suicide attempts by children. ✓ The need for agencies to make timely referrals for substance misuse support for young people. ✓ Access to specialist support to address issues relating to gender dysphoria in young people.	✓ Early closure of CIN plans in the context of neglectful parenting. ✓ Working with resistant/avoidant parents. ✓ Impact of children missing education and poor elective home education. ✓ Professional curiosity with regards to consideration of domestic abuse

Analysis of Case Review Activity

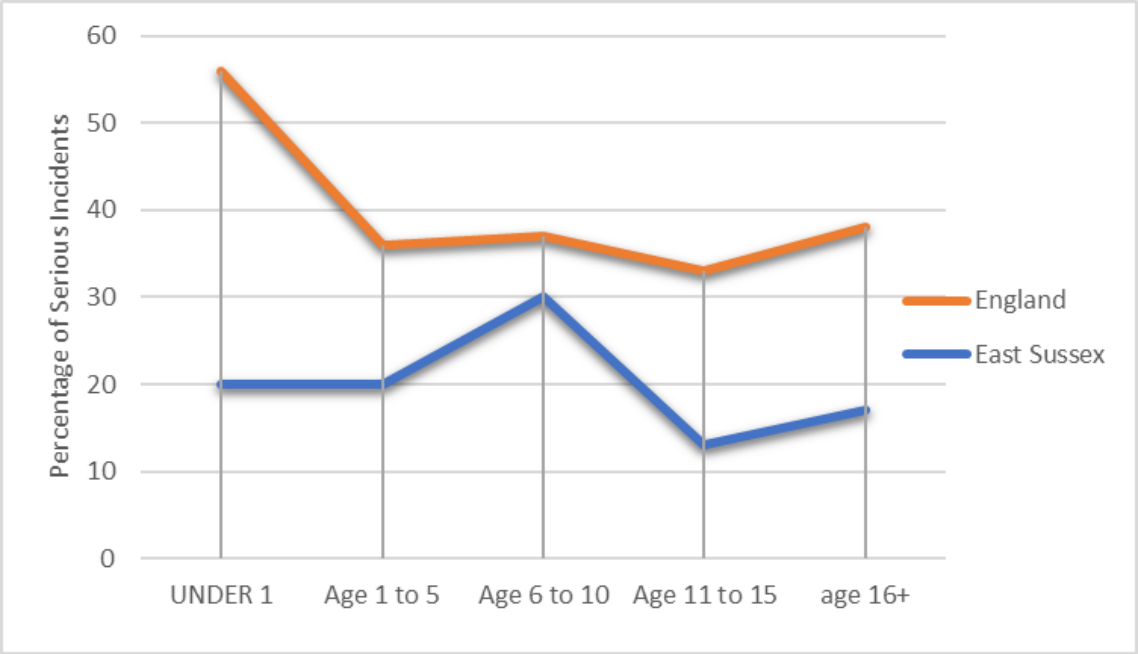


Since the Safeguarding Children Partnership arrangements began in East Sussex in October 2019, the partnership Case Review Group (CRG) has undertaken **17 Rapid Reviews**, resulting in **7 Local Child Safeguarding Practice Reviews** (figures up to March 23). A total of 30 children are the subjects of the 17 Rapid Reviews; 57% male, 43% female. This is in line with national figures, where males are the most common gender at 55%.

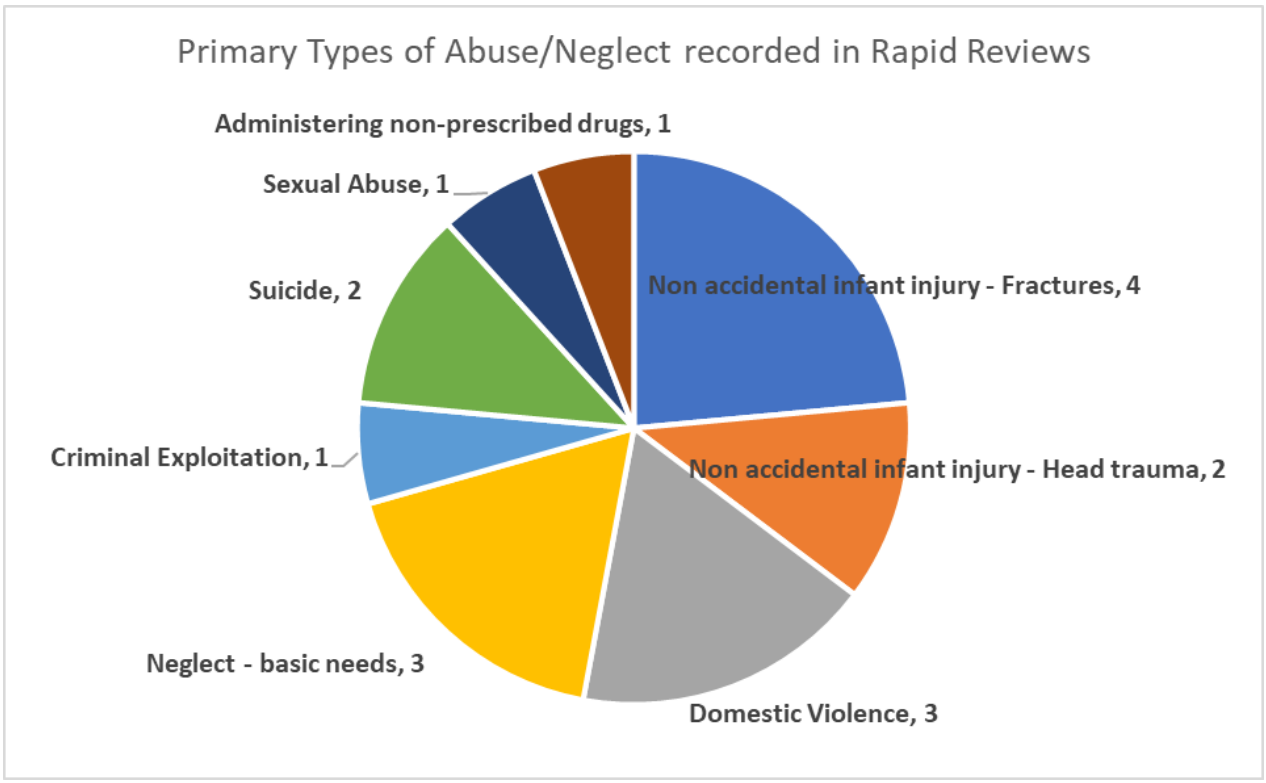
When under 1s and 1 year olds are combined they represent 30% of all children considered within rapid reviews in East Sussex. This age group featured predominately due to experiencing non-accidental injuries, such as fractures and abusive head trauma. This is in keeping with the national picture which also shows a predominance of infants under 1 amongst children involved in serious incidents notified to the National Child Safeguarding Practice Review Panel (35% of 456 children notified 2022/23)



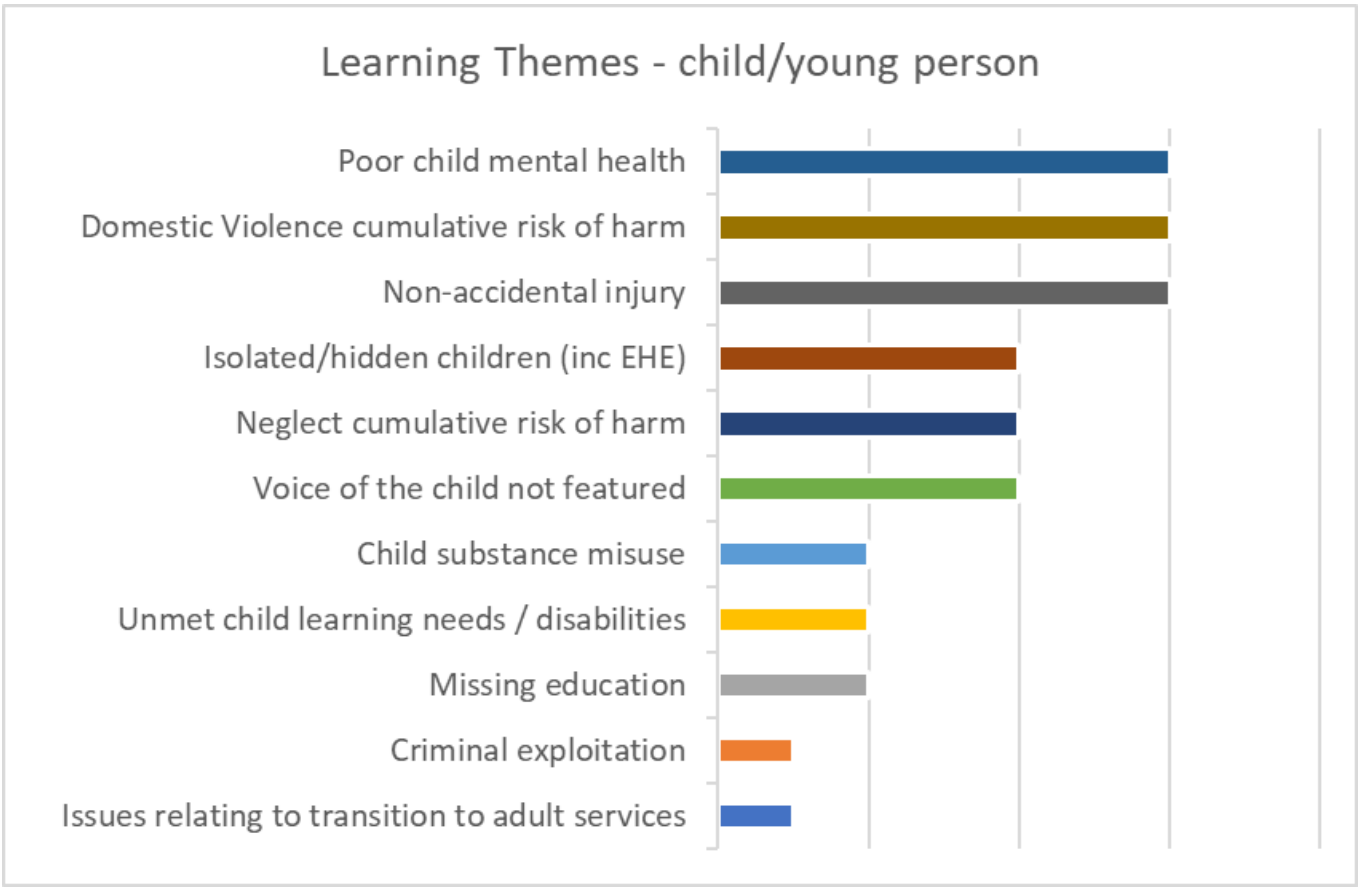
The Child Safeguarding Practice Review Panel Serious Incident Notification Statistics (May 2023) breaks age down into five categories. Over the same time period, the highest age category for England is under 1's (36%), whereas in East Sussex it is age 6-10 year olds (30%). This is due to three Rapid Reviews in 2021/22 in East Sussex that involved the neglect of three large sibling groups.

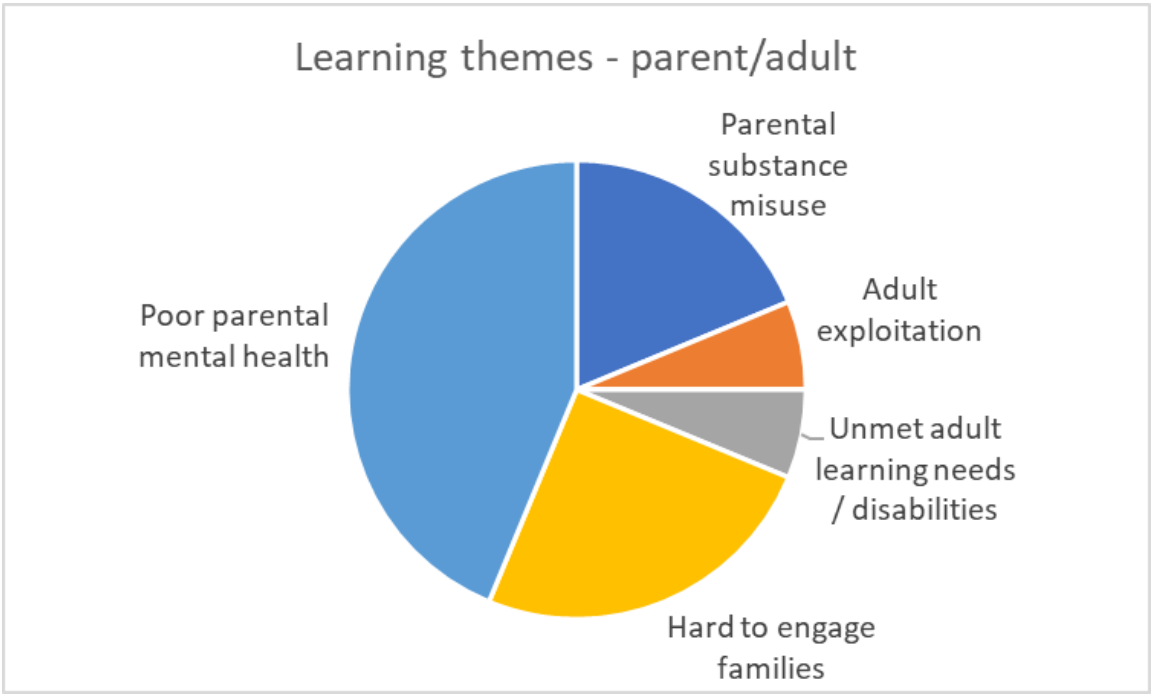


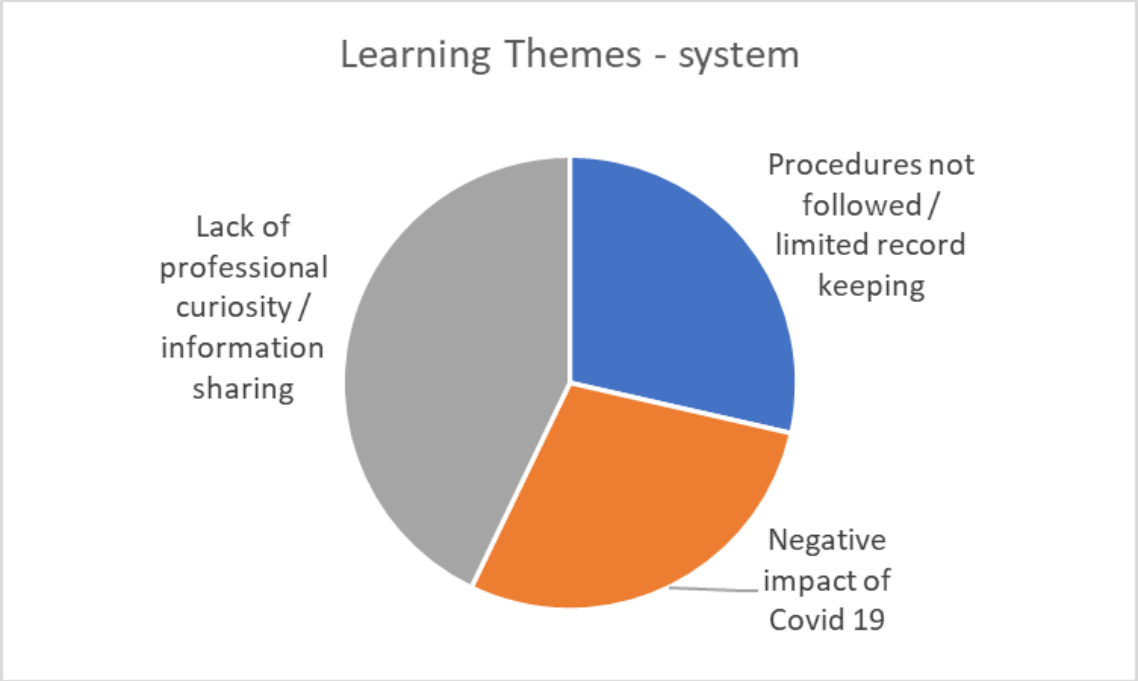
When the East Sussex rapid reviews are analysed by the primary types of abuse and/or neglect known in the family at the point of notification of the serious incident, non-accidental infant injuries (fractures and/or head trauma) featured in 6 of the cases; followed by neglect (3) and domestic violence (3). However, most cases involved complex families with multiple factors contributing to the safeguarding risk to the child/children.



Each Rapid Review and Local Child Safeguarding Practice Review can result in a number of key themes for learning. The tables below show the breadth of learning themes captured across the reviews undertaken since October 2019:







The five most commonly occurring learning themes in Rapid Reviews and Local Child Safeguarding Practice reviews are:

- Poor or unmanaged parental mental health
- Poor or unmanaged child mental health
- Fatal and non-fatal non-accidental fractures and head trauma injuries in under 2 year olds
- The cumulative risk of domestic violence
- Inadequate professional curiosity and information sharing between agencies

6.2 Quality Assurance Audits

The QA subgroup held **four audits** during 2022/23: a Pan Sussex audit on safeguarding children who were electively home educated; an audit on multi-agency response to the identification of initial need and risk, using the Joint Targeted Area Inspection criteria; a 'deep dive' audit of two cases of Harmful Sexual Behaviours (HSB) which occurred in school settings; and an 'appreciative inquiry' style audit into engagement of fathers and male carers in safeguarding practice.

Learning from the audits is shared at the ESSP Steering Group and one page learning briefings are shared with the wider ESSCP network and on the ESSCP website Quality Assurance Group - ESSCP. QA audit reports and one page learning summaries are now routinely shared at the Learning & Development Subgroup to ensure that learning arising from audit activity is more efficiently and effectively embedded into local training and learning activity.

Key learning included:

- ✓ The vital work schools do to safeguard children.
- ✓ The need for clear communication between the Police and key professionals when there are investigations following incidences of HSB in schools. This will allow schools to better understand and manage these complex situations.

- ✓ Training and support are crucial elements when dealing with HSB. Working collaboratively, sharing challenges, expertise and resources is incredibly beneficial when managing risk and safeguarding children.
- ✓ The importance for SWIFT and SARC involvement when a case involves HSB, so they consult and share resources with professionals.
- ✓ Professionals to challenge if not all statutory agencies are present at a Strategy Discussion.
- ✓ Challenging the myth that male workers are needed to engage fathers/male carers.
- ✓ Challenging unconscious bias around labelling father/male carers as a risk or perpetrators, and the impact this has on relationship building with the adults and outcomes for the child.

Further details on the ESSCP QA audits in 2022/23 can be found in the assurance section of this report. Following are examples of actions taken in response to learning arising from audits:

- The Pan Sussex audit of **safeguarding children who are electively home educated** highlighted to a range of professionals and agencies how safeguarding EHE children is everyone's responsibility, and the difficulties that services sometimes face when safeguarding EHE children. In most cases, education settings act as a protective factor in children's lives. Being in school increases the visibility of children and enables professionals with expertise in safeguarding to refer to other agencies as needed. Children who do not attend school often become hidden and the risks to their welfare are harder to observe. As a result, the Independent Chair and scrutineer of the Sussex Safeguarding Children Partnerships wrote to the National Safeguarding Panel and Secretary of State for Education, to share the learning from the review. The letter highlighted the lead safeguarding partner's concerns that the Government indicated that they will not be progressing the 'Schools Bill', which proposed the requirement for a statutory register of children who are EHE.
- The audit of the **'front door'** highlighted the need to review the referral pathway for ensuring timely cSARC (child sexual assault referral centre) engagement in cases where sexual abuse is suspected or known. In collaboration between SARC, East Sussex MASH and the ICB Designated Nurse for Safeguarding, it was agreed that for new referrals the MASH Health lead will provide the initial liaison with SARC. In cases where SARC do not feel there is a further role for them they will provide advice to MASH Health, which will be shared at the strategy meeting and added to the assessment plan.
- Learning arising from the **Harmful Sexual Behaviours** audit and the HSB Task & Finish group was promoted at the 'super' Designated Safeguarding Lead network for schools. This was presented in collaboration with the education safeguarding team, SWIFT and Sussex Police. This was attended by over 100 schools and colleges.

6.3 ESSCP Learning & Improvement Framework

The ESSCP Learning and & Improvement Framework was refreshed in 2021/22, with additional chapters on how the partnership uses 'Independent Scrutiny' and the 'Voice of the Child' to learn and improve local practice. The refreshed framework includes a stronger focus on how

learning will be disseminated and how partners will review and evaluate the impact learning has on practice. Following on from the framework, during 2022/23 the ESSCP has:

- ✓ Produced a public response to the two published LCSPRs (Child AA and Thematic Review), in order to achieve better transparency about how the partnership is responding to and learning from reviews.
- ✓ Delivered four lunchtime briefing sessions on learning from reviews. In total, over 200 staff across the workforce have attended these presentations on key themes and learning from LCSPRs.
- ✓ Delivered two 'evidencing impact' events with front-line practitioners and managers, including those involved in the original case, on the 'Child T' Serious Case Review (published in 2019) and a themed event on Infant Injury, which included the Child W and Child V SCRs. The events considered how the review impacted on practice and outcomes for children and families. More details can be found in the 'evidence' section of this report.
- ✓ Developed a Scrutiny Plan, which is monitored and steered by the ESSCP Planning Group, to ensure that the partnership is appropriately responding to national, and reoccurring local, safeguarding learning.

6.4 ESSCP Learning Strategy

The work of the ESSCP Learning and Development sub group is to ensure that East Sussex workforce and volunteers working with children, young people and/or adults who are parents/carers are provided with appropriate and effective multi-agency training to meet their needs, and that practice is underpinned with appropriate policies and procedures. The L&D Subgroup operated and discharged its functions in line with the ESSCP Learning Strategy (2020), which ensures that the ESSCP has a clear and shared vision as to the priorities for safeguarding learning and training and how this will be achieved. The Strategy aims are to:

- ✓ Ensure that safeguarding training/learning activities are based on local necessity and enable practitioners to recognise and respond to need and risk.
- ✓ Measure the impact of safeguarding training on practice and improving outcomes for children and young people.
- ✓ Ensure that learning from Local Child Safeguarding Practice Reviews, Audits, the Child Death Overview Process (CDOP) and the Voice of the Child is embedded into practice and ensures continuous learning and improvement.
- ✓ Ensure key safeguarding messages (local, pan-Sussex and national) are communicated.

6.5 ESSCP Training Programme

The ESSCP Learning and Development (L&D) Subgroup resumed several classroom-based training courses for Safeguarding Children Partnership partners in April 2022. As interest in the virtual sessions continues to be positive and, for shorter courses more cost effective, the future training programme will include virtual as well as classroom-based courses.

In September 2022 the East Sussex Learning Portal (ESLP) reverted to a temporary 'manual' system, due to the company who provided the existing Learning Portal going into liquidation. Consequently, the number of training courses offered during 2022/2023 (42) is lower than those offered during 2021/22 (63). The County Council Workforce Development Team worked incredibly hard to get a new booking system quickly into place to minimise the impact on the training programme.

Between 1st April 2022 and 31st March 2023, 42 training courses ran with 552 participants from a range of agencies attended, which equates to 68% attendance rate. A large majority of participants continue to rate courses as either Excellent (66%) or Good (33%).

New ESSCP courses were introduced from June 2022 onwards: *DASH, MARAC, and Safety Planning; Professional Curiosity and Professional Challenge within a Safeguarding Context* and *Working with Parents Effectively: Enabling Staff to deal with Difficult or Evasive Behaviour*. The latter two being areas highlighted in recommendations in both local and national Safeguarding Practice Reviews. *Contextual Safeguarding in East Sussex – the Local Context* and *Trauma-Informed approaches to working with Families in a Multi-Professional Context* have also been introduced during 2022/23. The latter benefits from input from 'Experts by Experience' and this is reflected in positive evaluation comments.

From April 2023 onwards new courses planned include *Equalities, Diversity and Inclusive Practice*, *Unaccompanied Asylum Seeking Young People* and a relaunch of the revised Neglect Toolkit and Neglect Matrix, and associated training.

7. Impact of Partnership Activity

This section aims to convey the impact of multi-agency and partnership activity on practice and outcomes for children and families.

Child AA LCSPR recommendations gave 3 areas of delivery focus.

- **Disruption** – quarterly highlight reports from the Serious Organised Crime Unit are now shared at MACE strategic. At a MACE operational level, the Police single agency escalation meeting was reviewed to ensure appropriate information sharing with partners at a client level.
- **Education** - embedded Education Review Meetings (ERMs) and development of the new Inclusion Partnerships (IPs) to discuss children of concern.
- **Transition** - a new Head of Service for LD and transitions has been appointed and holds the lead on this agenda. The Under 25's SMS is now receiving referrals for young people who use substances and are involved in criminal exploitation.

The **Child W LCSPR** raised concerns regarding the collection of Kennedy Samples at an out of county hospital site.

As a result, a new Standard Operating Procedure (SOP) for *Child Death Process in the Event of Unexpected Death Before 18th Birthday* was developed across the entire acute hospital Trust.

Following the **Child X LCSPR**, the tertiary hospital made significant changes to the trust wide safeguarding policy for documenting safeguarding concerns to coroners, introduced safeguarding supervision for the bereavement team and weekly meetings with the legal and safeguarding teams to ensure the cross referencing of cases.

Evidencing Impact Event – Child T SCR (2018)
Child T died in hospital, at the age of 18, due to complications caused by his Type 1 diabetes.
Practice change identified since the review:

- Improved knowledge and understanding (especially in schools) about life-limiting health conditions, and in particular how neglect of these conditions is a safeguarding issue.
- Improved identification and assessment of medical neglect safeguarding concerns, including clearer recurrent 'did not attend/was not brought' pathways.
- Development of transitions pathways and lead practitioners in health agencies.
- A greater focus across 'the system' on relationship based and trauma informed practice.

Evidencing Impact Event – Infant Injury: Event incorporated Child V and Child W SCRs (2019) and three Rapid Reviews (2020), all involving non-accidental injuries to babies. Practice change identified since the review:

- Improved information sharing across Health landscape, in particular between midwifery and health visiting.
- Increased professional knowledge and understanding of the vulnerability of infants, including increased awareness of ICON, safer sleeping messages, and indicators of non-accidental injuries.
- Improved engagement of fathers and other male carers, recognising there is still more to do.
- Improved culture of professional challenge.
- Embedded culture of 'corporate grandparenting'.
- Introduction of 'health' to MASH arrangements.

Safeguarding in Education priority impact:

Two preventative curriculum and Theatre In Education projects developed and delivered in partnership with Public Health.

Revised HSB Protocol, new screening tool and intervention packages shared with all education settings.

Pan-Sussex Unexpected Death toolkit and suicide awareness training rolled out for schools and colleges.

Multi-Agency Child Exploitation priority impact:

Disruption and Education - The introduction of Education Review Meetings has resulted in education improvements for 22/23 MACE cases, and it is envisaged that the opportunity for schools to refer their concerns at a lower threshold of risk via the new Inclusion Partnership meetings will result in more timely intervention for pupils and avoid the non-attendance or exclusion profiles identified within this cohort during previous case audits.

Safeguarding under 5s priority impact:

Improving practice and practice knowledge – the ESSCP has introduced 'light bite' sessions on safeguarding under ones, with the aim of increasing the number and range of professionals with safeguarding knowledge in this area. The sessions focus on increasing awareness and understanding of ICON, safer sleeping advice, and risk of injury and abuse of infants, including indicators to look out for. The course has been such a success it is planned to be implemented across Sussex.

Collaboration Against Child Exploitation (CACE) project is a service offer developed in partnership with parents who have 'lived experience' of exploitation. CACE includes an open access six week educational programme and monthly parent led self-support groups. There are ongoing service consultations with parents accessing CACE to ensure that delivery remains focused and targeted.

"I was so scared to come along to the course & felt I would be judged. How wrong was I!!! I never spoke to anyone outside the home … but at the group after a week I felt totally comfortable to speak out as I did not feel alone. The MACE workers are so approachable & never once did I feel judged".

"That we are not alone with our experiences and there are people we can speak to with advice or share experiences. Everyone was so lovely and supportive".

Voice of the child - Direct and indirect activity undertaken by the partnership includes:

- Each Board/Steering report is asked to consider how work is informed by the voice of child.
- Children involved in recruitment of Chair and Lay Members.
- Agency challenge and participation of care experienced young people in Section 11 scrutiny process.
- Childs view (and family) sought as part of case review process.
- Oversight of agency activity capturing children's views, such as Public Health *My health My School* survey.

What Children and Young People want from services:

Practitioners who are consistent, open, honest and genuine. Encouragement to express their views and not asking to repeat their story. To advocate on their behalf. Better help with mental health. Smoother transition between services.

8. Assurance

One of the roles of the ESSCP is to ensure the effectiveness of safeguarding practice, which it does through evidence-based auditing, performance management, and self-analysis. The SCP ensures that there is continual evaluation of the quality of services being provided, as well as effective communication and joint working between all SCP partner agencies.

The **Quality Assurance (QA) Subgroup** has the lead role, on behalf of the Partnership, for monitoring and evaluating the effectiveness of the work carried out by partners. It does this through regular scrutiny of multi-agency performance data and inspection reports, and through an annual programme of thematic and regular case file audits. This subgroup is chaired by the Detective Chief Inspector of the Safeguarding Investigation Unit in Sussex Police.

Examples of assurance undertaken by the ESSCP during 2022/23 include:

- The **ESSCP has an Independent Chair** whose function is to provide challenge and scrutiny of the effectiveness of the lead partners and other relevant agencies, via the Board and Steering Group meetings, and to also work with the lead partners to ensure the effectiveness of the safeguarding work carried out by partners. The approach of the Chair is to act as a constructive critical friend to promote reflection and continuous improvement and to provide support to that improvement. This included:
    - Reviewing and endorsing the recommendation to conduct one Local Child Safeguarding Practice Reviews (LCSPRs) arising from three serious safeguarding incidents;
    - Requesting assurance from the lead safeguarding partners that appropriate processes are in place, as highlighted in the National Child Safeguarding Panel review of the murders of Arthur Labinjo-Hughes and Star Hobson.
    - Raising concerns with agencies regarding participation in Child Protection Conferences and requesting agencies consider their responsibilities.
    - Overseeing the development of a partnership 'Scrutiny Plan' providing an overview for lead partners on key areas of challenge to multi-agency working and progress with responding to national learning.

- In addition to the Independent Chair, **three Lay Members** play a critical role in the partnership. The Lay Members act as further independent insight, on behalf of the public, into the work of agencies and of the partnership. As well as acting as critical friends at Board meetings, providing additional challenge and scrutiny, one Lay Member is a standing member of the SCP Case Review Group (CRG), and Lay Members are involved in the panel meetings for all LCSPRs. Their role has been critical at CRG, via the rapid review process and subsequent LCSPR process, in advocating the voice of the child. In 2022/23 the ESSCP recruited two new Lay Members (as two left the role in Summer 2022).

"I have now been a lay member of the East Sussex Safeguarding Children Partnership for five years. During that time I have learned much and been consistently impressed by the dedication of staff from all agencies and organisations involved, particularly given the difficult circumstances of the last few years. There is excellent collaboration and no sign of a destructive cycle of defensiveness. People challenge and

take challenge with respect and openness while remaining focused on children and their families.

One of the key functions of the Partnership is to provide training and to disseminate learning, both from reviews and more generally. Training is very well received, and the learning briefings are clear and widely distributed. However, I have been most impressed by the focus on the impact of these activities. Information and training are of no use unless they influence behaviour and change practice in such a way that the outcomes for children and their families are improved. The Partnership continues to strive to find ways of assessing impact and using this understanding to do things differently and so contribute to reducing the chance of children and young people coming to harm. This is also true in terms of how the Partnership supports improvements in safeguarding within organisations. They are not content with a tick box approach but look for ways to encourage reflective thinking and mutual challenge. None of this is easy but the Partnership shows no sign of giving up and I expect it to continue to make progress next year" **Harriet Martin**

"Although I have only been a Lay Member of the ESSCP for a short time, during this time I have witnessed some great examples of partnership working and found all partners to be truly dedicated to safeguarding children. Although much progress has been made, it is disappointing that "Safeguarding Under 5s" was not retained as a priority for the Partnership, as evidence shows the continued vulnerability of this age group. I have found the breadth and scope of the partnership training to be excellent". **Nick Porter**

"I joined the ESSCP as a lay member because I wanted to make a contribution to safeguarding children across the county. What I have found is a partnership full of highly specialised, committed professionals from a range of backgrounds who collaborate with care to promote good practice in safeguarding children against a very difficult backdrop.

There is a great deal of high level training to support the partnership and the communication is detailed and sensitive. What has struck me about the partnership is the high level of commitment and collaboration between professionals driven by shared goals and values who bring a great deal of safeguarding experience to a range of projects which have a real impact on children and their families across the county." **Anne Moynihan**

- The QA Subgroup reviews the '**ESSCP Performance Dashboard'** on a quarterly basis. The dashboard includes 60 performance indicators which are presented by: impact of multi-agency practice; children supported by statutory services; children with family related vulnerabilities; children with health-related vulnerabilities; and children whose actions place them at risk. Indicators are reviewed by the QA subgroup and escalated to the Steering Group if required. During 2022/23, performance indicators escalated by QA included:
    - **Indicator 25/26 (penetrative and non-penetrative sexual offences against children):** was escalated at Steering to consider the sustained increase in sexual offences recorded against children. Further investigation by the East Sussex Safeguarding Investigation Unit (Sussex Police) suggested that the increase in offences was, in part, due to an increase in awareness and reporting. The Steering

Group noted that the Police are dealing with more non-penetrative offences that have occurred in schools which are now referred to the Police, where previously schools may have dealt with these in house. Subsequently, the QA subgroup held a deep dive audit on 'harmful sexual behaviour', on two cases that occurred in school settings, to better understand multi-agency working in this context.

- **Indicator 45/46 (CAMHS completed within target timescales)** was escalated to Steering as the proportion of assessments within 4 weeks continued to be low over recent quarterly monitoring. The Service Manager for CAMHS explained that reporting on wait times had changed in 2022 - if a young person does not attend a planned appointment, this does not stop the waiting time clock (as it did previously). The robust SPFT 'Child Not Brought' (CNB) policy, to address potential safeguarding concerns around a young person not being brought to appointments, means that CAMHS will offer further appointments and proactive contact attempts, until the service has had direct contact with a young person and family for assessment. This means that some young people offered an initial appointment within 4 weeks may be waiting more than 5 months in total. The Service Manager noted that the CNB rate can be as high as 40% at initial appointment, resulting in high re-booking levels, delays in assessment and inefficiency costs. A project to reduce missed initial appointments was in place.

- The QA subgroup held **four audits** during 2022/23:

Safeguarding children who are **electively home educated** was chosen as a Pan Sussex audit theme given the significant increase in numbers, since the COVID-19 pandemic, across all areas of Sussex. The purpose of the audit was to understand how individual agencies respond to need and risk of vulnerable EHE children, and how agencies work together, including with local authority EHE teams, to safeguard children who are EHE. The audit was a useful tool to highlight, to a range of professionals and agencies, how safeguarding EHE children is everyone's responsibility and the difficulties that services sometimes face when safeguarding EHE children.

A key theme arising from the audit was the effectiveness of all Sussex EHE teams in terms of multi-agency communication, joint working, and participation in multi-agency safeguarding meetings. While there was some good evidence of direct work with the child/family, the challenge of seeing the child alone, or at all, meant that the child's voice, and understanding of their lived experience, was missing in too many of the audited cases, this was compounded by the constraints of EHE legislation that does not require parents to engage with services around EHE. The audit also highlighted there were examples of professional's variable understanding of when a safeguarding referral should be made in respect of educational neglect and/or educational neglect was not given sufficient weight within assessments and decision making.

Following the publication of the *National Review into the murders of Arthur Labinjo-Hughes and Star Hobson*, partners agreed to hold an audit on the **'front door'** in September 2022. The objective of the audit was to get a view on the system and evaluate how effectively individual agencies identify and respond to need and risk, how timely and effective the multi-agency response is, and the impact of responses to safeguard children and in improving outcomes for the child.

The key theme emerging from the audit was the impact of capacity issues, across all agencies, on the timeliness of response to referrals. Whilst the most acute cases received a timely response through the front door, some cases presenting with lower risk were delayed in being allocated. Information sharing at the front door appeared strong, with roles, responsibilities, and thresholds well understood and embedded. Several cases also identified issues around the strategy discussion process, around either the initial identification of strategy discussion threshold being met, or quoracy and multi-agency representation at the meeting itself.

This multi-agency audit provided a valuable opportunity to take stock of areas of strength and areas of development requiring focus. It was evident through the process that there is an embedded understanding across the agencies of thresholds, importance of information sharing, timely referrals and focus on the child's experience. Recommendations in response to the audit learning have been taken forward, including:

- The appointment to the newly established post, ***Strategic Lead for MASH, Assessment and Safeguarding*** offers additional management and leadership capacity to oversee and develop further the effectiveness of the 'front door'.
- Ensuring quoracy at strategy discussions, and continued promotion of the 'Statement of Professional Differences' procedure in strategy discussions to support multi-agency challenge.
- Multi-agency MASH practice development sessions commenced in January 2023, involving health, social care and Police, focussing on front door actions and threshold decision.
- **Continuing drive to ensure MASH resource meets demand:** the MASH has seen a continued increase in demand over the past few years with a 21% increase in contacts coming into MASH in 2023/23 compared to 2020/21. MASH capacity is a regular item on the ESSCP Risk Register, which is owned by the three safeguarding lead partners. To mitigate the pressure on MASH;
    - Additional Saturday MASH sessions have been implemented when demand requires additional capacity.
    - Revised guidance has been launched to improve efficiency in MASH with regards to case recording, through succinct summarising of history, checks and decision making.
    - Additional Practice Manager capacity has been added to the East MASH and DAT. There has been successful recruitment of experienced social workers into recently vacated posts. Additional Practice Manager capacity in the West MASH is being recruited to.
    - Both MASH Teams continue to benefit from having dedicated Health representatives (in post in the Teams since June 2022). This is considered essential to the MASH approach and significantly strengthens partnership approach to safeguarding.
    - Police have increased their capacity by 0.6 FTE and are working towards continuous and consistent office presence across both MASH's.
- Continuing recruitment drive for health visitors and continuing focus on staffing within the Duty and Assessment Teams to address issues of timeliness in completion of assessments. Assessment timescales have significantly improved across 2023 to date.
- Ensuring the unallocated work protocol to maintain management oversight on unallocated cases in the MASH and Duty and Assessment Teams is robustly applied. Subsequent audits have evidenced the unallocated work protocol to be embedded.
- To maintain a view on the system and evaluate the effectiveness of the front door, there is a programme of twice yearly auditing of the front door, led by social care and including MASH Health. The last audit was completed in March 2023, which evidenced an overall improvement in the response to MASH referrals through the processing of MIGs, the

allocation and completion of timely Family Assessments, and strategy discussions being convened promptly. An additional quality assurance mechanism involves weekly audits of MASH episodes exceeding timescales.

The QA subgroup held a 'deep dive' audit of two cases of **Harmful Sexual Behaviour.** The purpose of the audit was to better understand multi-agency working in response to allegations of harmful sexual behaviour (HSB), which have occurred in a school setting, and to test the impact of work resulting from the ESSCP Task & Finish Group on HSB. It was agreed that a 'deep dive' audit approach would work well, where two cases were looked at in detail with front-line professionals and managers. One case occurred in a secondary school setting and the second case occurred in a primary school setting.

The common theme of the audit was the challenge schools face between managing risk and safeguarding of children, and this impact this has on the wider school community. All agencies attending felt they had a better understanding of how these types of incidences can impact on a community and how they can support schools to provide timely information to manage the situation. There was some excellent good practice identified in terms of school safety planning and multi-agency working.

The findings of the audit were shared at the schools DSL supernetwork meeting in January 2023, noting how seriously this issue is viewed across the partnership and recognition of the difficulties for schools in managing these types of situations.

QA subgroup held an appreciative style audit on the theme of **'Unseen Men'**, which focused on the engagement of fathers and other male carers in safeguarding work. Unseen men has been an ongoing area of focus for the partnership, given the learning both locally and nationally on how male partners and carers often go 'unseen' by services engaged with children. This includes learning from a number of local children safeguarding practice reviews and audit findings (engagement of fathers, partners and other male carers is a standard component of all ESSCP QA audits).

The QA group agreed that a powerful way to capture and audit work in this area would be to hold an 'appreciative' style audit, where ten safeguarding cases were selected, where there was good engagement of males: either where they posed a risk to the child and successful engagement by services reduced that risk and/or they were successfully engaged to ensure the child was protected/nurtured. The approach was positively received by front-line practitioners and managers and provides a basis for sharing learning on 'what works' rather than what isn't working.

The key theme arising from the session was that the skills to engage fathers/male carers are the same skills used to engage mothers, and challenging the myth that only male workers can engage fathers/male carers successfully. Learning also included giving due regard to significant males in all assessment and planning, especially when they have parental responsibility; challenging unconscious bias around labelling fathers/male carers as a risk or perpetrators, and the impact this has on relationship building with the adult and outcomes for the child; and tailoring the support which is on offer when what's offered doesn't 'fit'.

- The Partnership has a key role in **evaluating the effectiveness of support for looked after children and care leavers** – it does this via the annual scrutiny of the ESCC Annual Looked After Child & Care Leaver Report, the Annual Independent Reviewing Officer (IRO) report, regular monitoring of key performance information in the ESSCPs quarterly dashboard, and

via the Section 11 process. In particular, the Steering Group have scrutinised the management of the increased number of unaccompanied asylum-seeking children placed in the county.

- The Partnership has a key role in **evaluating the effectiveness of early help services** – it does this via the regular monitoring of key performance information in the ESSCPs quarterly dashboard.

- In 2022/23 the ESSCP, along with Brighton & Hove SCP and West Sussex SCP, held its seventh bi-annual '**section 11' audit**. All organisations represented on the ESSCP were requested to complete a self-assessment and provide evidence of how they comply with s11, of the Children Act 2004, when carrying out their day-to-day business. The audit provides an indication of how well organisations are working to keep children safe. The 2022 section 11 audit was framed more as an 'improvement' tool, rather than simply demonstrating compliance with the standards, with agencies encouraged to rate themselves as amber where improvement could be identified. Peer Challenge events are organised for summer 2023, include a Pan Sussex peer challenge event in June, a challenge event in July for ESCC teams, and a further peer challenge event for the district and borough councils. An action plan has been developed for the top ten lowest rated standards which is overseen by the Learning & Development Subgroup.

- The Annual **Schools Safeguarding Audit Report (s175)** was presented to the ESSCP Board for scrutiny and challenge in October 2022. All schools (including maintained, independent, academies, free schools, and colleges) in East Sussex are requested to complete the safeguarding audit toolkit on an annual basis, assessing their practice in line with statutory guidance and local good practice. Engagement with the process is strong with 100% of state funded schools returning their audit. A bespoke audit tool for independent schools, which aligns with the Independent School Inspection Framework, has been developed to increase engagement with the audit process from the independent sector. The audit provides all schools with a robust framework against which they can evaluate their practice and identify areas for development as necessary and the data gathered by SLES Safeguarding, through having the audits returned to them, informs the ongoing development of guidance, training and support to schools. For the current academic year SLES Safeguarding have developed a tool for school governors to use, which will support their scrutiny and challenge of safeguarding practice and will facilitate some deeper thinking around practice. This in turn will strengthen the integrity of the self-assessment process.

- Other examples of assurance work undertaken include:
  - ✓ **Health Visitor numbers and service capacity** has been a regular item at the ESSCP Steering, Planning and Board during 2022/23. Over the past year, the service continues to experience high vacancy rates with implications on the capacity of the service to identify safeguarding concerns with the families on their caseloads and provide support to prevent concerns escalating. Lead Safeguarding Partners have closely monitored the situation, ensuring all relevant agencies are aware of the impact of the situation, and agreeing strategies to reduce and mitigate safeguarding risks. In January 2023 the lead partners agreed to establish a multi-agency Task & Finish Group to review the ability

of health visiting services to deliver antenatal review and attend statutory meetings in the long term.

- ✓ **(Oct 22) Scrutiny at Board of the report from the Manager at Lansdowne Secure Children's Home**, highlighting safeguarding and behaviour management practice at the unit over the past year. Annual presentation of this report to the ESSCP is a regulatory requirement given the significant vulnerability of young people in secure establishments. The Board noted the unit's approaches to managing behaviour, episodes of single separation and use of restraint. The effective relationships between staff and the children and young people were evident, with staff able to use support strategies in response to incidents, resulting in positive interventions and a further decline in physical interventions over the course of the year. The homes relationship-based trauma informed care has led to the stabilisation of children's behaviours, and in most cases, this has led to the successful development and positive progress of children. The home was inspected by Ofsted in December 2022 and received a 'Good' judgement. From February 2023 the unit was temporarily closed due to ongoing challenges regarding staff recruitment, resulting in only being able to utilise a small proportion of the places in the unit. The unit is undergoing a review and redesign of the staffing structure and developing an enhanced recruitment strategy to allow a resilient and sustainable service in the future. The unit is due to re-open in November 2023.

9. Appendices

9.A Safeguarding Context

Impact of multi-agency working		
Family contacts (to SPOA and other excluding MASH)	↑	The total number of contacts is up 5% on last year (17,798 compared to 17,011) however the increase is not as steep as the previous year (29%).
Information gatherings by Multi-agency Safeguarding Hub (MASH)	↑	The number of multi-agency information gathering (MIG's) also increased by 8% (21,181 compared the 19,572 in the previous year).
Referrals to statutory social care	↓	In 2022/23 the number of referrals to statutory social care was 6% down from last year (4018 compared to 4,169) but still higher than 2020/21.
Privately Fostered children	↓	Following a peak at 80 in summer 2022, the number of Privately Fostered children fell to 35 at the end of 2022/23. This is lower than the number at the end 2021/22.
Children supported by statutory services		
Children with a child protection plan	↑	The number of CP plans has continued to rise throughout 2022/23 to a peak of 691 at the end of March 2023. This is 29% higher than in March 2022 (536).
Looked After Children	↑	The number of looked after children has increased (6%) to 664 at the end of March 2023, compared to 628 at the end of March 2022. This is partly driven by the increase in Unaccompanied Asylum Seeking Children.
Unaccompanied asylum-seeking children	↑	There were 73 unaccompanied asylum-seeking children in East Sussex at the end of March 2023, higher than at the same in March 2022 (57).
Young people at high risk of child exploitation	↑	There were 22 children within the SAFER cohort at the end of March 2023: 12 at high risk and a further 8 at amber level of risk. This is higher than the March 2022 figure of 18 active cases.

Sexual offences against children	↑	The number of sexual offences (penetrative and non-penetrative) has increased over the past year, from a total of 542 in 2021/22 to 570 in 2021/22. This continues the trend seen over the past few years.
Children with family related vulnerabilities		
Children living with domestic violence (MARAC)	↑	There were 128 cases reviewed by MARAC at the of March 2023 compared to 83 at the end of March 2022. There was a total of 206 children in households of cases held by MARAC at the end of March 2023.
Vulnerable young carers	↓	There were 328 children's social care assessments completed in 2022/23 where a young carer was identified as a factor, this is a decrease compared to 371 in the previous year.
Children educated at home	↑	1514 children were recorded as being electively home educated at the end of March 2023, compared to 1358 at the same point in 2021.
Children with health related vulnerabilities		
Children with disabilities with a Child Protection Plan	↑	At the end of March 2022 there were 22 children with disabilities with a child protection plan. This represents an average of 3% of all CP plans compared to 4% at the end of 2021/22.
Children attending A&E due to self-harm	↑	692 children in 2022/23 attended A&E in East Sussex hospitals due to deliberate self-harm, an increase from 612 the previous year.
Referrals to child mental health services	↔	A total of 3607 new CAMHS referrals were received in 2022/23, slightly lower than the previous year, but still continuing the significant upward trend seen since 2021.
Children whose actions place them at risk		
Missing episodes	↑	There were a total of 2083 missing episodes in 2022/23, a 48% increase on the previous 2021/22 figure of 1404.
Births to under-18 year olds	↑	Awaiting Qtr. 3 & 4 data. There were 11 live births in East Sussex hospitals to children under the age of 18 in the first half of 2022/23.
Young people entering the youth justice system	↓	62 young people entered the youth justice system for the first time in 2022/23 compared to 100 in 2021/22.
Young people held overnight in Police custody	↔	There were only 11 occasions of young people being held overnight in Police custody in 2022/23, the same as in 2021/22

9.B: Board Membership - up to March 2023

NAME	TITLE, ORGANISATION
Chris Robson (Chair)	Independent East Sussex SCP Chair
Louise MacQuire-Plows	Manager, East Sussex SCP
Victoria Jones	Manager, East Sussex SCP
Harriet Martin	Lay Member, East Sussex SCP
Anne Moynihan	Lay Member, East Sussex SCP
Jacqueline Muntzer	Lay Member, East Sussex SCP **(to July .22)**
Nick Pointer	Lay Member, East Sussex SCP
Maxine Nankervis	Partnership Support Officer, East Sussex SCP

Domenica Basini	Asst. Dir. for Safeguarding & Quality, NHS England **(to April .22)**
Gail Gowland	Head of Safeguarding (Adults and Children), East Sussex Healthcare Trust
Gareth Knowles	SECAmb Trust Safeguarding Lead, Clinical Supervisor
Jackie Dyer (Job Share, LT)	NHS England and NHS Improvement – South
Jayne Bruce	Deputy Chief Nurse, Sussex Partnership Foundation Trust (SPFT)
Jo Tomlinson	Assistant Head of Safeguarding Children/Designated Nurse, NHS Sussex
Judith Sakala	Named GP for Child Safeguarding, NHS Sussex
Lynne Torpey (Job Share, JD)	NHS England and NHS Improvement – South
Martin Ryan	Named Nurse/Associate Director Safeguarding Children
Michael Brown	Head of Safeguarding and Looked After Children, NHS Sussex
Naomi Ellis	Director of Safeguarding & Clinical Standards, NHS Sussex
Sergio Lopez-Gutierrez	Designated Nurse Safeguarding Children for NHS Sussex
Tracey Ward (Deputy Chair)	Designated Doctor Safeguarding Children, NHS Sussex
Vikki Carruth	Director of Nursing, ESHT

Andrea Holtham	Service Manager, Sussex CAFCASS **(to July .22)**
Dave Springett	Detective Superintendent, Public Protection, Sussex Police
David Kemp	Head of Community Safety, East Sussex Fire & Rescue Service
Debbie Knight	Head of East Sussex Probation Delivery Unit
James Collis	Chief Superintendent, Sussex Police
Jon Hull	D/Sup Sussex Police **(to July .22)**
Kate Kirwan	Service Mngr, Sussex Children & Family Court Advisory Support Service CAFCASS

Annabel Hodge	Dir. Of Safeguarding, Bede's Senior School
Kate Bishop	Rotherfield Primary **(to Jan.23)**
Richard Green	Deputy Head Teacher, Chailey Heritage School

Richard Preece	Executive Head teacher, Torfield & Saxon Mount Federation

Alison Jeffery	Director of Children's Services
Amanda Glover	Operations Manager, ESCC
Ben Brown	Consultant, Public Health, ESCC
Bob Bowdler, Cllr	Lead Member for Children and Families
Catherine Dooley	Senior Manager, Standards and Learning Effectiveness (5-19), Children's Services
Douglas Sinclair	Head of Safeguarding and Quality Assurance, Children's Services
Fraser Cooper	Head of Safeguarding Adults
Justine Armstrong	Safer Communities Manager, ESCC
Kathy Marriott	Assistant Director (Early Help & Social Care), Children's Services
Lucy Spencer	Safeguarding Adults Board Development Manager
Rachel Doran	Legal & Coroner Services Manager, ESCC
Vicky Finnemore	Head of Specialist Services, Children's Services

Charlotte O'Callaghan	Senior Policy Officer, Wealden District Council (Maternity Leave)
David Plank	Director, Child + Adult Safeguarding, Wealdon District Council
Jeremy Leach	Principal Policy Adviser, Wealden District Council **(to Oct.22)**
Malcolm Johnston	Executive Director for Resources, Rother District Council **(to March .23)**
Peter Hill	Policy Officer, Wealden District Council, Wealdon District Council
Seanne Sweaney	Strategy and Corporate Projects Officer, Lewes DC and Eastbourne BC
Verna Connolly	Head of Personnel & Organisational Development, Hastings Borough Council

Kate Lawrence	Chief Executive Home-Start East Sussex

9.C ESSCP Budget

ESSCP – Actual Income and Expenditure 2022/23:

Income 2022/23		Area of Spend	Confirmed Expenditure
Sussex Police	£35,000	Independent Chair	£23,500
NHS Sussex	£53,400	Business Manager(s) & Administrator	£115,327
East Sussex County Council	£124,500	Administration	£1,535
Training Income	£5,508	Learning & Development Consultant	£59,268
ESSCP brought forward from 2021/22	£23,855	Training Programme and Conferences	£6,933
		Projects (QA and Data support)	£16,533
		Pan Sussex Procedures	£7,031
		IT Software & Hardware	£1,368
		Safeguarding Practice Reviews	£7,717
		cfwd (balancing fig)	*£3,051**
Total	**£242,263**		**£242,263**

***The £3,051 carry forward is due to ongoing review author activity initiated in 2022/23, therefore this amount is already allocated to known safeguarding review expenditure.

Projected Expenditure for 2023/24:

EXPENDITURE CATEGORIES	Details	Forecast
Independent Chair	Based on 26 days	£26,269
Business Managers	Inc. travel allowance, not inc. 23/24 pay award	£94,366
Administrator	Not inc. 23/24 pay award	£24,001
Administration	Includes; TASP membership, Mobile phones/laptop cards, Board/Steering/QA deep dive venue cost once a year, ESSCP website and Misc. Admin costs	£5,229
Learning & Development Consultant	Inc. travel allowance, not inc. 23/24 pay award	£59,886
Training Programme and Conferences	Multi-agency Training Programme external training delivery and venue costs	£13,197
QA & Data Support	QA Dashboard and Quality Assurance support (£12,500)	£16,500
Pan Sussex Procedures	PSP Co-ordinator role and website contribution	£7,310
IT Software & Hardware	Misc. IT costs	£250
Safeguarding Practice Reviews	Includes activity already undertaken on current reviews, 1 x LCSPR and 1 x Evidencing Impact event	£10,050

9.D Links to other documents

CDOP annual reports - Sussex Health and Care (ics.nhs.uk)

The 2021/22 Annual Report from the Sussex Child Death Overview Panel (CDOP) was presented at the ESSCP Board in October 2022. Through the process of reviewing child deaths, CDOP identified several matters of concern affecting the safety and welfare of children in the area as well as wider public health or safety concerns arising from a particular death or from a pattern of deaths in the area. Key learning and recommendations from the reviews completed during 2021/22 included:

- ✓ Extensive thematic suicide panel learning
- ✓ Deaths from road collisions overseas
- ✓ Medical management of SEN children who are unable to describe their symptoms
- ✓ Senior clinical oversight providing safe effective care and ensuring that parental concerns are listened to and given appropriate weight
- ✓ Smoking cessation support offered to all in the households of pregnant mothers
- ✓ Importance of eliciting from mother the amount and frequency of alcohol being consumed during pregnancy
- ✓ Importance of sharing information between professionals, particularly where separate record systems do not support the effective sharing of information

East Sussex Health and Wellbeing Strategy

This strategy is a framework for the commissioning of health and wellbeing services in the County. The Health and Wellbeing Board will consider relevant commissioning strategies to ensure that they have taken into account the priorities and approaches set out in the Health and Wellbeing Strategy.

The main priority is to protect and improve health and wellbeing and reduce health inequalities in East Sussex. To enable us to do this over the next three years the strategy will focus on: Accountable care; Improving access to services; Bringing together health and social care; Improving emergency and urgent care; Improving health and wellbeing; Improving mental health care; Improving primary care; Better use of medicines; Better community services.

East Sussex Children and Young Peoples Plan

The Children and Young People's Plan (the CYP Plan) is the ten-year ambition for partners in the Children and Young People's Trust.

The CYP Plan shows how partners in the Children and Young People's Trust work together to improve outcomes for children and young people. It focuses on those who are vulnerable to poor outcomes.

Sussex Police and Crime Commissioner – Police and Crime Plan 2021-24

The Commissioner has identified the following four policing and crime objectives:

- Strengthen local policing
- Work with local communities and partners to keep Sussex safe
- Protect our vulnerable and help victims cope and recover from crime and abuse
- Improve access to justice for victims and witnesses

East Sussex Safer Communities Partnerships' Business Plan 2020-23

The East Sussex Safer Communities Partnership undertakes a strategic assessment of community safety every three years with an annual refresh in order to select work streams and plan activity for the year ahead.

Colleagues from the ESSCP and ESCC Children's Services work closely with the Safer Communities Partnership to respond to the broader threat of exploitation. Sustaining existing work within the partnership and developing new and existing relationships with partners is of particular importance to ensure that we are supporting vulnerable individuals within the community and helping them feel safe and confident in their everyday lives.

East Sussex Safeguarding Adult Board Strategic Plan 2021-24

The ESSCP works closely with the SAB on the overlapping themes of Modern Slavery, Domestic Abuse, and Cuckooing. The two boards are also collaborating on a needs analysis for the cohort of 18 to 25 year olds who may be at risk of exploitation to identify any current gaps in service provision.

East Sussex Youth Cabinet

The Youth Cabinet members are young people aged 11 to 18 years old. They are elected to represent the views of young people in East Sussex. Members of the Youth Cabinet gather the views of young people through:

- surveys
- workshops
- events
- creative consultation

9.E Acronyms

ABE	Achieving Best Evidence
AMH	Adult Mental Health
CAFCASS	Children and Family Court Advisory and Support Service
CAMHS	Child and Adolescent Mental Health Service
CCG	Clinical Commissioning Groups
CDOP	Child Death Overview Panel
CQC	Care Quality Commission
CRG	Case Review Subgroup
CSARC	Children's Sexual Assault Referral Centre
CSP	Community Safety Partnership
CYPT	Children and Young People Trust
DAT	Duty and Assessment Team
DfE	Department for Education
EET	Education, Employment, or Training
EHE	Electively Home Educated
ESFRS	East Sussex Fire & Rescue Service
ESHT	East Sussex Health Trust
JTAI	Joint Targeted Area Inspection
LAC	Looked After Children
LADO	Local Authority Designated Officer
LCSPR	Local Child Safeguarding Practice Review
LSCLG	Local Safeguarding Children Liaison Groups
MACE	Multi-Agency Child Exploitation Group
MASH	Multi-Agency Safeguarding Hub
NPS	National Probation Service
SAB	Safeguarding Adults Board
SCARF	Single Combined Agency Report Form
SCP	Safeguarding Children Partnership
SCR	Serious Case Reviews
SECAmb	South East Coast Ambulance
SLES	Standards and Learning Effectiveness Service
SPFT	Sussex Partnership Foundation Trust
SPOA	Single Point of Advice
STP	Sustainability and Transformation Plan
SUDI	Sudden Unexpected Death in Infancy
SWIFT	Specialist Family Services
YOT	Youth Offending Team

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Report to: **East Sussex Health and Wellbeing Board**

Date of meeting: **12 December 2023**

By: **Executive Managing Director, East Sussex, NHS Sussex and Director of Adult Social Care and Health, East Sussex County Council**

Title: **East Sussex Shared Delivery Plan (SDP) programme update**

Purpose: **To receive a progress report on the Sussex Integrated Care System (ICS) joint Shared Delivery Plan (SDP), as it relates to delivering the agreed Health and Wellbeing Board (HWB) priorities for the population of East Sussex.**

RECOMMENDATIONS:

East Sussex Health and Wellbeing Board (HWB) is recommended to:

1) **Note the content of the progress report; and**
2) **Note the outline proposals being developed for a strengthened East Sussex 'Health, Care and Wellbeing Partnership' and accountability to the Health and Wellbeing Board, which will be brought to the March meeting of the HWB.**

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1. Background

1.1 Delivery Area 4 in the Shared Delivery Plan (SDP) *Our plan for our population* builds on our East Sussex Health and Wellbeing Strategy *Healthy Lives, Healthy People* (2022 – 2027), and sets out eight key milestones in 2023/24 related to our shared priority programmes and projects for our East Sussex population covering:

- Children and young people
- Mental health
- Community, including a new joined-up community approach through the development of Integrated Community Teams (ICTs)
- Health outcomes improvement

1.2 The eight milestones also align with, and in some cases directly support, delivery in East Sussex of pan-Sussex objectives in the SDP for long term, immediate and continuous improvements. These are being managed through the eleven new pan-Sussex Delivery Boards that have been set up to support the SDP. These arrangements have continued to bed in and there is membership in common across the pan-Sussex Delivery Boards and our key East Sussex Place-based governance groups, including our four Oversight Boards that are responsible for delivering programmes of change in the above areas and the Health and Care Partnership Board.

1.3 The purpose of this report is to share a summary of progress with the following strategic developments that are being led by our East Sussex Health and Care Partnership:

- East Sussex SDP programme progress
- Local development of Integrated Community Teams (ICTs)
- Strengthening our East Sussex Place Partnership collaboration across health, care and wellbeing

2 Supporting information

East Sussex SDP programme progress

2.1 The eight high level East Sussex SDP commitments and milestones are set out in **Appendix 1** for ease of reference. A brief summary of the East Sussex SDP programme highlights across the four East Sussex priority programmes at Place is contained in **Appendix 2**. In quarter 4 of 2023/24 we will review our progress across all eight commitments and milestones, including the milestones being delivered through pan-Sussex partnership activity, in order to update our plans for 2024/25 (year 2 of the SDP). This will be reported to the HWB meeting in March 2024.

2.2 A review is also underway to confirm or reconfirm our shared critical priority objective measures and key performance indicators (KPIs), to ensure these support our understanding of progress and impacts. This work is being progressed through each Oversight Board in line with the stage of development for their programme.

2.3 Our approach to understanding and coordinating our work more broadly at Place level across the different shared intelligence and insight requirements we have is also being reviewed. A focussed meeting in December will bring together public health and business intelligence leads across our organisations to explore and co-design how we can collaborate across these functions to support a shared understanding of the needs, impacts and outcomes for our population. Discussion will take in our planning across the following:

- Developing data-driven population health management and including our understanding of needs, risks and strengths within our new ICT footprints
- Measuring the improvements we are seeking through transformation and integration, to support our strategic ambition to deliver improved shared health and care outcomes, as set out in our HWB Strategy

Local development of Integrated Community Teams

2.4 As discussed at the last meeting of the HWB, Integrated Community Teams (ICTs), will be made up of professionals working together as a 'team of teams' across different organisations with local communities, individuals, and their carers. This will involve integrated working across primary care, community, mental health, local authority partners, voluntary, community and social enterprise organisations and other local partners.

2.5 The year one milestones for Integrated Community Teams include having a clear model informed by Joint Strategic Needs Assessments, Health and Wellbeing Strategies, and local population data and insights from local people and communities. In East Sussex we have agreed five ICT 'footprints' based on our borough and district boundaries, and initial work will be progressed through an ICT community 'frontrunner' in Hastings.

2.6 To ensure a consistent approach across Sussex there is a pan-Sussex ICT Delivery Board. The East Sussex Community Oversight Board is the programme board responsible for leading ICT implementation in East Sussex, alongside similar Place-focussed delivery arrangements in Brighton & Hove and West Sussex. In light of this Community Oversight Board (COB) relaunched in October 2023 having refreshed its terms of reference and membership to reflect this new role, and the links with the pan-Sussex ICT Delivery Board.

2.7 In addition to co-designing the emerging overarching principles and framework for ICT delivery, our current focus is the scope and next steps for our implementation of ICTs in the East Sussex context across their key functions within the emerging framework, including:

- Planning: making changes based on data and evidence for their communities
- Improving population health and tackling health inequalities
- Integrating health, care and wellbeing services at the local level
- Creating appropriate models of care with and for communities to deliver agreed outcomes

2.8 To ensure we build on progress, our learning and insight from our existing integrated care developments and current pilot programmes and projects, including the Universal Healthcare project in Hastings, has been reviewed to inform shared areas of focus and next steps. More detail is contained in **Appendix 2**, including the planning for establishing an initial ICT in Hastings as our community frontrunner in quarter 4 2023/24, to establish a blueprint model for establishing ICTs in all five footprints in East Sussex.

Strengthening our East Sussex Place Partnership collaboration across health, care and wellbeing

2.9 At the inception of the Sussex Integrated Care System (ICS) there was local agreement that 'Place' is key to strategic leadership, local commissioning and delivery within the ICS. This was to help enable a clear focus on population needs and get the best value out of the full range of collective resources available to improve the health, care and wellbeing of the population. This also reflects our local context in relation to local democratic accountability, strategic planning structures and collective resources available for populations, and also national policy expectations as set out in the White Paper for health and social care integration (February 2022): *Joining up care for people, places and populations*.

2.10 At East Sussex 'Place' level the East Sussex Health and Care Partnership brings together local NHS partners including NHS providers and Primary Care Networks (PCNs) with representatives of the County Council, Borough and District Councils, East Sussex VCSE Alliance and Healthwatch. The Partnership acts as a forum for the local strategic management of integration activity and oversees delivery of the East Sussex elements in the Shared Delivery Plan (SDP), with accountability to the East Sussex Health and Wellbeing Board (HWB).

2.11 The September report to the HWB signalled that discussions were taking place with Borough and District (B&D) Councils about shaping our current 'East Sussex Health and Care Partnership' into a 'East Sussex Health, Care and Wellbeing Partnership'. This is with the intention of further strengthening our collaboration across shared programmes of work where there are connections to services and policy such as economic development, planning, housing, leisure, wellbeing and environmental services for local communities.

2.12 It has also felt timely and important to develop proposals for our HWB more broadly aimed at strengthening our ability to collaborate to deliver an integrated offer of health, care and wellbeing in our communities across care, prevention and the wider determinants of health. This will refresh and strengthen our accountability to the HWB in its statutory role and responsibility for the East Sussex population, as well as be in keeping with the role of the HWB and Place in our Integrated Care System.

2.13 To progress this the following steps have been taken:

- The terms of reference for the key partnership groups within our Place health and care governance have been shared to help identify where all five B&D Councils should be represented, and where this could be done collectively to support capacity.
- Ahead of this B&D Councils have agreed to each be represented on the Community Oversight Board, as we move into implementing our Integrated Community Teams model. This will help strengthen our focus on prevention as part of improving health outcomes for our population as well as the integrated offer of health, care and wellbeing to individuals with more complex care needs within the ICT model, and nominations are underway for this.
- Discussion has taken place with Borough and District housing leads to explore and shape initial proposals for further strengthening the specific relationship between health, social care and housing specifically within our partnership and programme governance to support improved outcomes. Appropriate reporting of key shared strategic partnership priorities and programmes concerning housing has also been explored within this.
- The East Sussex Housing Partnership Board considered and endorsed a suggested initial approach at its meeting in November, and this will be fed back to B&D Council Chief Executives as part of the next steps to finalise proposals. The finalised proposal will be

considered at the March 2024 meeting of the Partnership Board, ahead of being brought to the HWB for endorsement.

3. Conclusion and reasons for recommendations

3.1 Joint work in East Sussex has continued to take place to progress delivery of our objectives across our HWB Strategy SDP priorities for children and young people, mental health, community and improving population health outcomes. Involvement in the new SDP Delivery Boards at a pan-Sussex level has also continued to be cemented to align planning, commissioning and delivery to ensure improvements for our population. An overview of progress in 2023/24 across all of our HWB objectives in the SDP will be brought to the next meeting.

3.2 In the context of our new Sussex ICS and developing pan-Sussex governance arrangements, the existing core East Sussex Health and Care Partnership governance has been kept under review in 2023/24, to ensure capacity and resources are aligned to support effective collaboration at Place. This is intended to both support our ICS and continue to ensure accountability to the East Sussex HWB in overseeing an integrated offer of health, care and wellbeing for the East Sussex population, as set out in the White Paper for health and social care integration: Joining up care for people, places and populations (February 2022). Pending further discussion with local partners in the coming weeks, including Borough and District Councils, the VCSE sector and Healthwatch, finalised proposals will be brought to the next meeting of the HWB for consideration.

JESSICA BRITTON
Executive Managing Director, East Sussex, NHS Sussex

MARK STAINTON
Director of Adult Social Care and Health, East Sussex County Council

Contact Officer

Vicky Smith, Programme Director East Sussex Health and Care Transformation

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Appendices
Appendix 1 East Sussex HWB SDP milestones
Appendix 2 Draft East Sussex programme progress summary

Appendix 1
East Sussex HWB SDP milestones

	What we will do (2023/24) ***(East Sussex HWB SDP milestone)***	**What we will achieve**	**When**
ES1	Building on the Universal Healthcare initiative and other local programmes, we will have a joined-up approach to planning and delivering health, care, and wellbeing in Hastings, with clear evidence of integrated approaches to improving outcomes for local communities.	A planning and delivery approach agreed by Place leadership board.	**March 2024** **In progress**
ES2	Service models will be developed and approved for scaling up across the county and an implementation timetable with key milestones agreed.	Service models will be approved by Place leadership board.	**March 2024** **In progress**
ES3	A comprehensive stakeholder engagement process will take place to help us explore how we can improve health outcomes in cardiovascular disease (CVD) respiratory disease, mental health, and frailty/ageing as significant drivers of poor health and early death in our population.	Improvement plans approved by Place leadership board.	**March 2024** **In progress**
ES4	Aligned to our discharge workstream, we will develop our integrated hospital discharge model, implement the 2023-24 hospital discharge capacity plan, and deliver the improvements aligned with the discharge frontrunner programme.	More people will be able to be discharged safely to a community setting.	**March 2024** **In progress**
ES5	Deliver our children and young people's programme plan with a key focus on priority workstreams to support getting the best start in life; promoting emotional wellbeing and mental health; physical health, needs of children with SEND, and our most vulnerable young people.	Family hubs with additional support for families with young children; strengthened support for long term conditions (Core20PLUS5 for CYP); clearer and improved pathway for mental health support and support for parent carers.	**March 2024** **In progress**
ES6	We will deliver initial stages of integrated models of community mental health care within local communities, through Primary Care Network based offers and developing plans to support more people who need housing-based support due to their mental health.	In-year plan delivered	**March 2024** **In progress**
ES7	Networks will be developed in communities to help co-ordinate access to local sources of practical support and activities, to boost emotional wellbeing and help with loneliness and isolation.	Consolidation of networks providing access and support to local people.	**March 2024** **In progress**
ES8	Develop our approach as an "anchor" system in East Sussex, including our plans for using our power as employers and buyers of services to stimulate sustainable economic and social wellbeing in our communities.	Approach approved by Place leadership board.	**March 2024** **In progress**

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Appendix 2

East Sussex Health and Wellbeing Board (HWB) Shared Delivery Plan programme highlights

September – December 2023

1) Introduction

Our East Sussex Oversight Boards for children and young people, mental health, community and population health outcomes improvement are each responsible for overseeing and delivering the East Sussex Health and Wellbeing Board Strategy priorities that are set out in our Sussex Shared Delivery Plan (SDP). A brief summary of the progress highlights across all four East Sussex HWB priority programmes is set out below.

Children and young people

In keeping with the East Sussex SDP objectives for 2023/24, the aim of the East Sussex Children and Young People Health Oversight Board (CYPHOB) is to continue to develop and implement the children and young people priority programmes and projects, and to ensure that agreed service improvements, including pathway and service redesign are effectively implemented through collaborative working between commissioners and providers of health, mental health and care services. The following progress has taken place over the autumn period:

- A focus on progress with Family Hub developments and the Perinatal Equity and Equality Plan has been considered to promote the best start for life and best outcomes for babies and young children and their families.
- Work is being taken forward to develop accessible information, advice, guidance and self-help for children and young people's mental health and emotional wellbeing. The Board has considered the Loneliness Project and the impact of loneliness on children and young people and families.
- The development of pan-Sussex weight management and childhood obesity plans was considered to understand and inform the service offer for children and young people.
- The development of a comprehensive health dashboard for children and young people continues to be progressed by the CYPHOB to complement work sponsored through the pan-Sussex Children's Board. This work will consider the CORE20Plus5[1] groups previously endorsed by the CYPHOB and the pan- Sussex Children's Board.
- Joint work is being taken forward to develop a specific health strategy for looked after children, care leavers and unaccompanied asylum-seeking children.
- The CYPHOB has reviewed and agreed the joint East Sussex County Council and Sussex ICB Special Educational Needs and Disabilities (SEND) Commissioning Statement. The focus of the statement is to provide a shared commissioning approach to meet the strategic aims and priorities outlined in the East Sussex SEND Strategy 2022-25 and the priorities for continuous improvement set out in the SDP.

[1] *The NHS Children and young people 'Core20Plus5' framework was published November 2022 (the Core20Plus5 for Adults was published in November 2021). The framework is an approach to support the reduction of health inequalities in children and young people at both national and system level. It defines target population cohorts and identifies:*

- *'5' focus clinical areas requiring accelerated improvement; Asthma; Diabetes; Epilepsy; Oral Health, and; Mental Health.*
- *The 'Core20' most deprived 20% of the national population as identified by the national Index of Multiple Deprivation (IMD).*
- *'Plus' ICS-chosen population groups experiencing poorer-than-average health access, experience and/or outcomes, who may not be captured within the Core 20% alone, and would benefit from a tailored healthcare approach or accelerated focus. In East Sussex these are: looked after children and care leavers; children and young people with a learning disability or autism or life limiting illness; young carers, and; asylum seekers and migrants who have been staying in cohort hotels and in our communities living with families.*

Mental health

In addition to the pan-Sussex SDP mental health improvement priorities and in keeping with the East Sussex HWB SDP objectives for 2023/24, the East Sussex Mental Health Oversight Board (MHOB) has agreed a set of project plans aimed at taking forward its four priorities of dementia, homelessness, improving access and data and intelligence. The MHOB has also agreed to progress high level ambitions related to the development of older people's mental health services in East Sussex. The ambitions relate to improving available data, improving awareness and access to services, developing integrated pathways and delivering bespoke older people's offers. The following progress has taken place over the summer period:

- Emotional Wellbeing Services (EWS) are now operational in six PCNs in East Sussex, and it is expected that EWS services will go live in the Havens PCN in the first week of January. Place-based workshops took place in September aimed at exploring increased integration between primary and secondary mental health service offers to widen access. Outcomes are being brought together locally to enable a road map to be drafted.

- The Plan has been refreshed for the Place-based approach to delivering improvements across the next 18 – 24 months for Housing and Supported Accommodation. The plan re-confirms the commitment to the local priorities for improving integration between mental health and housing services, developing a potential 'Discharge to Assess' style step down accommodation model subject to available finances and increasing the overall supply of supported accommodation placements in the county. An additional priority of improving quality across the offer has also been included.

- A multi-agency working group has been established to look at enhancing the local Dementia pathway with an ambition of improving focus on prevention, reducing crises and becoming less reliant on inpatient care in conjunction with a stronger community offer. Work is underway to co-produced a set of shared priorities and a plan.

Community and integrated community teams

The broader strategic programme for Integrated Community Teams (ICTs) is led through the existing Community Oversight Board (COB), which reports to the East Sussex Health and Social Care Executive Delivery Group and wider Partnership Board. After the early work to agree the ICT footprints across Sussex including the five for East Sussex based on borough and district boundaries, strategic engagement has continued to take place to raise awareness about the opportunities that ICTs bring. The COB underwent a refresh exercise to ensure its terms of reference reflected the leadership role in implementing ICTs in East Sussex. This included updating its membership across health, social care, borough and district councils and the East Sussex VCSE Alliance to reflect the full breadth of ICT functions related to the delivery of integrated care and improved population health.

The COB was relaunched in October and the focus has been on supporting the development of the five East Sussex ICT data profiles, agreeing the scope and phasing of our Place-focussed implementation of ICTs across their key expected functions and aligning resources to support delivery. This is taking place alongside co-designing the emerging Sussex-wide framework and principles for developing ICTs, and the shared approach to communications and engagement that will support this. The following progress has been made:

- The data packs bringing together our initial understanding of population health and service needs for each ICT footprint have been developed, with accompanying packs of qualitative data themed around existing community insights. These will be available to support the initial phase of ICT establishment in January – March 2024, starting with Hastings as our community 'frontrunner'. The next steps will be to finalise the first phase programme plan to make a start with key functional areas of ICTs that make sense in our East Sussex context and in line with Health and Wellbeing Board expectations, including:

- Establishing a framework to support joint planning and delivery across ICT footprints driven by local data and insight
- Revisiting our target operating model for community health and social care to widen its scope and align it with our five ICT footprints
- Exploring joint duty and triage and identifying where an integrated approach across Social Care, Community Health, Mental Health, Primary Care and VCSE teams will add the most value
- Refreshing our approach to care coordination and multi-disciplinary team working across primary care, community health and social care, mental health and housing and voluntary, community and social enterprise sector teams (VCSE) teams

- Our extensive learning from previous integrated care developments and current pilot projects and engagement has been reviewed to inform this. This includes the Universal Healthcare proposition in Hastings, and pilot-work to use data to identify and target local community-based support at frail older people in Lewes. Our broader programme approaches to supporting local community networks, social isolation and loneliness and asset-based community development will also be instrumental to ICT development.

- A focussed senior leadership planning meeting has taken place between NHS Sussex, ESCC (Adult Social Care, Children's Services and Public Health), Hastings Borough Council, East Sussex Healthcare NHS Trust, Hastings Primary Care Network, Hastings Voluntary Action and Hastings Community Network to agree the next steps for developing our ICT 'blue print' in Hastings as our community frontrunner, building on local activity and engagement there, including Universal Healthcare. This has identified some specific opportunities and challenges in the Hastings context that the local ICT could helpfully focus on to add value as part of initial development activity. The next steps will be to identify service and team leads to begin the process of setting up the ICT in January through an initial development session that will explore these further.

Health Outcomes Improvement (HOI)

A new programme to align work and activity aimed at health outcomes improvement is being established as part of progressing Shared Delivery Plan milestones in East Sussex, aligned with existing activity and team resources both locally and across Sussex. Our key focus is a small number of health conditions where there are significant opportunities to promote better health at the earliest stages and intervening early, to prevent or delay situations getting worse through improvements to care pathways that help with current levels of need. The conditions are cardiovascular disease, chronic respiratory disease, mental health and frailty/healthy ageing. These all significantly drive inequalities in life expectancy and healthy life expectancy in our population and data, evidence and good practice shows they can be impacted through modifying risk factors in our population. The following progress has been made:

- The Improving Health Outcomes in East Sussex planning workshop took place on 3rd November. It was attended by 73 people from local NHS, ESCC, District / Borough councils and VCSE teams and services. The workshop focused on service mapping and action planning for the four conditions as well as identifying common themes across all four conditions to shape integrated responses and pathways. Participants collectively considered:
  - What is currently being delivered and what is working well
  - What are the key challenges and collaborative opportunities
  - What would make the biggest difference most quickly
- Work is now underway to review, capture and theme the outputs from each of the groups to inform a set of priority actions and next steps for each area to support pathway improvements and longer-term change. This will be completed and finalised for review by the Health Outcomes Oversight Board on 19th December.

The Oversight Board has also considered the East Sussex Healthy Weight Plan 2021-2026 reflecting on key achievements, challenges and opportunities. Actions were agreed to strengthen partners' strategic and operational understanding to embed physical activity into policies and processes, community engagement/co-production and working with local food outlets to improve access to healthier food.

Report to:	**East Sussex Health and Wellbeing Board**
Date of meeting:	**12 December 2023**
By:	**Director of Public Health**
Title:	**East Sussex Joint Strategic Needs Assessment (JSNA) Update**
Purposes:	**To present to the Health and Wellbeing Board an update on the JSNA for East Sussex.**

RECOMMENDATIONS

The Board is recommended to approve the JSNA priorities and workplan for 2024.

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1. Background

1.1 The Joint Strategic Needs Assessment (JSNA) programme was established in 2007 and reports on the health and wellbeing needs of the people of East Sussex. It brings together detailed information on local health and wellbeing needs to inform decisions about how we design, commission, and deliver services to improve and protect health and reduce health inequalities. The JSNA is an on-going, iterative process, led by Public Health within the County Council.

1.2 Statutory guidance for Joint Strategic Needs Assessments states that the responsibility for overseeing JSNAs lies with the Health and Wellbeing Board (HWB) and this has been reiterated in guidance on health and wellbeing boards published in November 2022. In East Sussex this process has been led by Public Health on behalf of the Health and Wellbeing Board.

1.3 Since January 2012, all JSNA work and resources have been placed on the East Sussex JSNA website so that it provides a central resource of local and national information relevant to East Sussex.

1.4 Resources include local needs assessments, local briefings on specific topics, direct links to national tools containing local data, Director of Public Health Annual Reports, and signposts to other useful resources such as East Sussex in Figures (ESiF).

2. JSNA developments since the last report to HWB

2.1 There have been many updates to the JSNA since last December, here are just a few highlights:

- New website launched February 2023
- DPH report 2022/23 - Connecting People and Places
- Life Course Summary
- District and Borough Area Profiles
- Children and Young People Self-Harm Needs Assessment
- Pupil Health & Wellbeing Survey Data Summaries
- Several Census 2021 reports
- Creative Health, Arts and Culture resources
- Briefings on the economy and benefit claimants in East Sussex
- Gambling briefing
- Vision briefing
- Prostate cancer briefing

3. JSNA Refresh progress.

3.1 There were five items presented to the board last December as part of the workplan for 2023/24. These were:

1. Complete the transfer of current JSNA resources to interim JSNA site whilst ESiF replacement is developed.
    - This was completed in February 2023.
2. Publish accessible overviews of key issues across the life course.
    - This was Published in June 2023
3. Publish strategic summaries for each of the Big Three JSNA questions.
    - The Healthy Life Expectancy and Health Inequalities summaries are being finalised. The third summary relating to Need and Demand across the health and care system to be carried over in to 2024.
4. Publish the key priorities from the JSNA based on work to date.
    - New JSNA priorities identified by the JSNA process are being presented to the board in this report to then be published in the New Year.
5. Continue integration with ESiF replacement developing area profiles and local data to be explored by users.
    - Update on progress with integration is presented within this report.

JSNA Framework

3.2 The JSNA working group continue to meet monthly to ensure the work is on track and focused on the right tasks. In September the group reviewed the JSNA website content against the JSNA Framework (see Appendix 1) to feed into the JSNA workplan for 2024 to ensure that gaps are identified, and new resource requirements identified to go on the task list.

Integration with East Sussex in Figures (ESiF).

3.3 The ESiF website was first created at the request of the East Sussex Strategic Partnership 17 years ago to provide a single source of data and information about the county. It continues to be well used, both within the Council and by partner agencies, the voluntary, community and social enterprise sector, businesses, and members of the public. It is a trusted and valued source of information, particularly for demographic and economic statistics. As previously reported to HWB the current design of the site does not meet modern accessibility requirements as set out by the Public Sector Bodies (Websites and Mobile Applications) Accessibility Regulations 2018 and it is not possible to fix these without rebuilding the entire site and the software behind it.

3.4 The project to replace ESiF and integrate with the JSNA site has been overseen by the East Sussex County Council (ESCC) Digital Board and work has been taken forward by a working group to identify the technical requirements for the replacement solution. This included accessibility and security requirements. An assessment of the market identified one solution that met the requirements which is currently in the process of being procured for use.

3.5 The site will be launched in early 2024 and once the new site is up and running, the next stage is to integrate the ESiF and JSNA sites as planned.

Governance changes

3.6 Last December we agreed a governance structure with the HWB to support the East Sussex JSNA. Since then, there have been some changes to the East Sussex Health and Care system with a new governance structure for partnership planning, delivery and transformation at East Sussex Place level within the Sussex Integrated Care System (ICS). Within this new structure

will be the creation of an East Sussex Population Health and Care Intelligence Group. This is shown within appendix 2 of this report. It is proposed that the JSNA working group feed into this group and receive requirements from this group in the planning and development of JSNA resources.

4. Proposed priorities for the system based on JSNA work to date.

4.1 The current JSNA priorities were based on work undertaken for the 2018/19 Director of Public Health's annual report. Based on the JSNA work to date, here are the proposed new JSNA priorities for 2024.

Building blocks of good health – Decent Home, Education and Employment alongside Good Social Connections and Community.

Building on the following JSNA resources:

- Health and Housing – DPH report 2019/20
- Work Skills and Health – DPH report 2021/22
- Connecting People and Places – DPH report 2022/23
- Creative Health Position Paper

Importance of the Life course approach – Good Start in Life, Living Well, Ageing Well, A Good End in Life.

Building on the following JSNA resources:

- Life Course Summary

Improving Healthy Life Expectancy – Extending years in good health by enabling healthy behaviours and reducing risk and impact of chronic disease and ill-health.

Building on the following JSNA resources:

- Healthy Life Expectancy Summary

Reducing Health Inequalities – Underpinning everything we do. Gaps are always changing and not always in the direction we want them to.

Building on the following JSNA resources:

- Health Inequalities summary

Mental Health and Wellbeing - focussing on prevention and early support.

Building on the following JSNA resources:

- Adult Mental Health Prevalence Briefing
- Pupil Health & Wellbeing Survey Data Summaries

5. Workplan for 2024

5.1 The proposed workplan below sets out some key pieces of work identified from the JSNA framework gap analysis and also requests received. This list is not comprehensive and there will be the need to respond to requests as priorities emerge throughout the year. Where appropriate the work will look at the whole life course.

Major work that takes substantial time to plan and complete.

- Integrated Community Teams (ICT) - Support development of data profiles across the whole of Sussex, with the first set delivered in December 2023.
- Mental Health – Work focussed on supporting the Mental Health Oversight Board.
- Frailty – Work to support the Health Outcomes Improvement Oversight Board.
- Oral health – Focussed work on priority groups for the NHS Sussex commissioners.
- Community survey – Creative Health and Wellbeing Community Survey.
- Climate Change JSNA – Working with the Healthy Places team in Public Health.

Briefings

- Healthy Ageing data pack
- Active travel.
- Learning disabilities, autism, and neurodiversity for adults.
- Air quality
- Cancer

Profiles

- Adding and updating profile pages on the site as they become available from organisations such as the Office for Health Improvement and Disparities (OHID), Office for National Statistics (ONS), other Government departments, Local Government Association (LGA) etc.

6. Conclusion and Reason for Recommendation

6.1 The Health and Wellbeing Board is recommended to:

1. Agree the approach and governance for the JSNA programme.
2. Agree the JSNA Priorities
3. Approve Sign-off the workplan for 2024

DARRELL GALE
Director of Public Health

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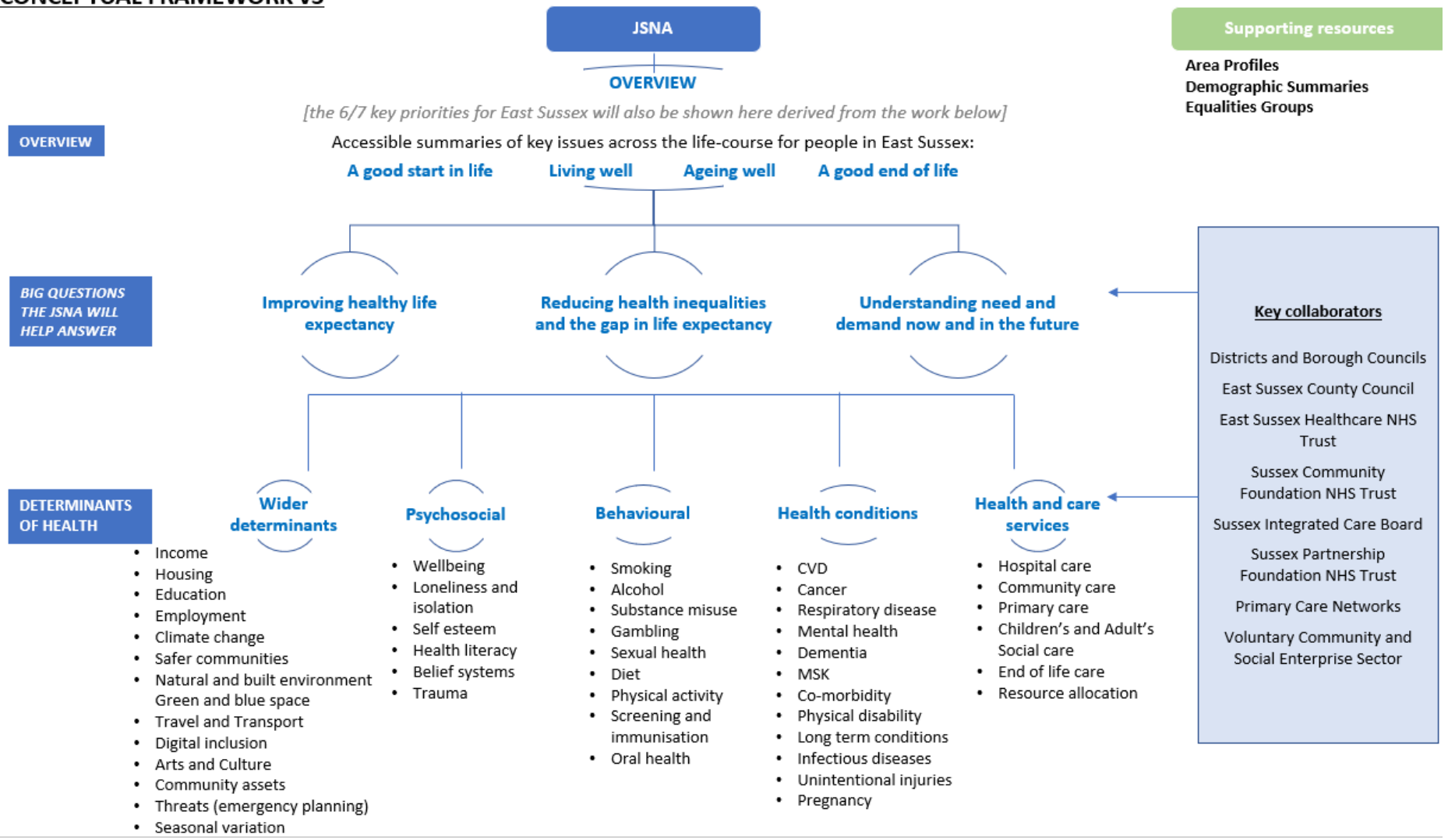
APPENDIX 1

JSNA CONCEPTUAL FRAMEWORK v3



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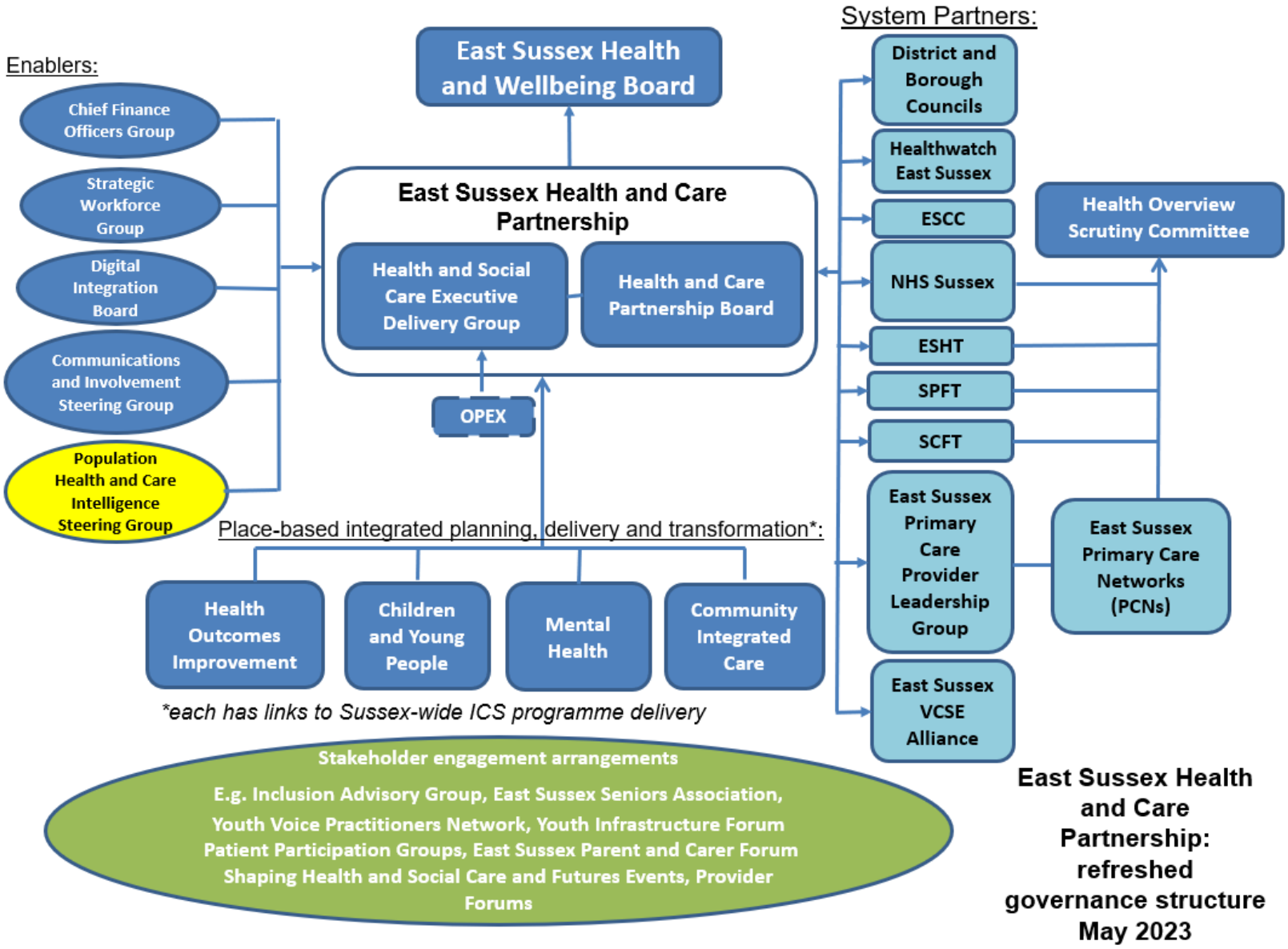
APPENDIX 2 – East Sussex Health and Care Partnership and programme governance



East Sussex Health and Care Partnership: refreshed governance structure May 2023

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Report to:	**East Sussex Health and Wellbeing Board**
Date of meeting:	**12 December 2023**
By:	**Darrell Gale, Director of Public Health**
Title:	**Sussex and East Sussex Suicide Prevention Strategies**
Purpose:	**To update the Board on the development of suicide prevention strategies and action plans for Sussex and East Sussex**

RECOMMENDATIONS: **The East Sussex Health & Wellbeing Board is recommended to:**

1) To note the recent and ongoing work to develop and implement the two suicide prevention strategies and action plans for Sussex and East Sussex.

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1 Background

1.1 The aim of this paper is to update the Health and Wellbeing Board on the actions being taken to reduce the risk of death by suicide across Sussex over the next three years, including the first year of our East Sussex 3-year action plan.

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.

1.3 The rate of suicide in East Sussex of 12.1 per 100,000 people (approximately 68 deaths per year). This exceeds the England average of 10.4 and is sat between the rates in other parts of Sussex with Brighton and Hove at 14.1 and West Sussex at 11.5. Of the 5 district and boroughs in East Sussex, rates are highest in Eastbourne (19.6), and the lowest is Rother (9.4).

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 strategy emphasises the role of the wider system, including the Integrated Care System (ICS) in co-ordinating action to prevent suicides.

1.5 Historically local plans have been shared with the East Sussex Health and Wellbeing Board. West Sussex and Brighton and Hove are also developing local plans to accompany the Sussex wide strategy, and each will be shared with respective Health and Wellbeing Boards during November and December 2023.

2 Supporting Information

2.1 Sussex Collaboration and Strategy 2024-2027

2.1.1 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.

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

2.1.3 As this NHS England funded programme came to an end, the need to refresh the strategic approach across Sussex became apparent and a pan-Sussex suicide prevention strategy was developed by the Sussex Suicide Prevention Steering Group. Membership of this group includes NHS Sussex, Sussex Partnership NHS Foundation Trust, Sussex Police, Voluntary and Community sector representatives and the three upper tier local authorities. The need for a Sussex-wide strategy was also raised in response to multi-agency actions following clusters of suspected deaths by suicide across divergent communities and geographies in 2021.

2.1.4 The Sussex strategy was signed off by the Sussex Mental Health Learning Disability and Autism Board in September 2023. Following publication of the national strategy[1] later that same month, the Sussex Strategy was given minor updates to reflect the latest national guidance (see Appendix 1).

2.2 East Sussex Action Plan 2024-27

2.2.1 The East Sussex action plan attached to this report was developed with the help of the East Sussex Suicide Prevention Steering Group (see Appendix 2). This multi-agency group includes representatives from East Sussex County Council, NHS Sussex, Sussex Partnership NHS Foundation Trust, the voluntary, community and social enterprise sector, Sussex Police and wider partners. It's formal reporting line is to the Sussex Suicide Prevention Group, but it also provides updates to the East Sussex Mental Health Oversight Board and Children and Young People's Health Oversight Board.

2.2.2 There is also a Coastal Suicide Prevention Group and a suicide prevention partnership/ network that includes a wider membership of organisations that support suicide prevention. The latter is predominantly an information sharing and networking forum.

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

2.3 Key National and Local Funding Sources

2.3.1 Historically, national NHS England funding was provided to Integrated Care Systems. Sussex Health and Care Partnership received £1,584,000 over 3 years from 2019/20 to 2021/22 with a further £120,000 for a suicide bereavement support service for 4 years from 2020/21 to 2023/24.

2.3.2 The new national strategy published in September 2023 states that NHS Long Term Plan funding to support suicide prevention activity, including to support specific groups, should continue to run from March 2024[2].

2.3.3 The shortfall in funding for bereavement services beyond March 2024 is a pressing concern and has been raised with colleagues within the Mental Health Learning Disability and Autism Board. Currently the funding contributes to four bereavement services: Cruse in West Sussex, Rethink in Brighton and Hove and SSOS in East Sussex. Winstons Wish are commissioned to provide a service to children bereaved by suicide across Sussex.

2.3.4 The Government have launched a new £10 million Suicide Prevention Grant Fund for voluntary, community and social enterprise (VCSE) organisations coinciding with the national strategy, to assist in the delivery of the national suicide prevention strategy actions until March 2025. However, there has been a very high number of applications and therefore a relatively low level of funding may be allocated to local projects when counted as a whole. We are aware that some local VCSE partners have bid for this funding, including a pan-Sussex consortium bid submitted by Grassroots charity in Brighton.

3. Conclusion and reasons for recommendations

3.1 Suicide prevention planning across Sussex is well developed, and there is a high degree of collaboration between the three local authorities and other partners. The Sussex strategy focusses on actions where it is felt that a pan-Sussex collaborative approach will make best use of resources and yield the best results. Work to implement one year action plan within the Sussex strategy is underway, but progress with some elements will depend on the available resource to take them forward.

3.2 The East Sussex action plan summarises key local actions that help contribute to the national priority areas and meet local challenges. The East Sussex Suicide Prevention Steering Group will contribute towards the pan-Sussex work but also continue to oversee our local plan and identify further areas for improvement and development in our preventative approach.

3.3 The Board is asked to note the recent and ongoing work to develop and implement the two suicide prevention strategies and action plans across Sussex and East Sussex.

[2] Suicide prevention strategy: action plan - GOV.UK (www.gov.uk)

Darrell Gale
Director of Public Health

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LOCAL MEMBERS

All divisions are covered by this report.

Appendix 1 – Sussex Suicide Prevention Strategy and Action Plan 2024-27

Appendix 2 – East Sussex Suicide Prevention Framework and Action Plan 2024-27

Sussex Suicide Prevention Strategy and Action Plan

2024 -2027

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

Contents

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)

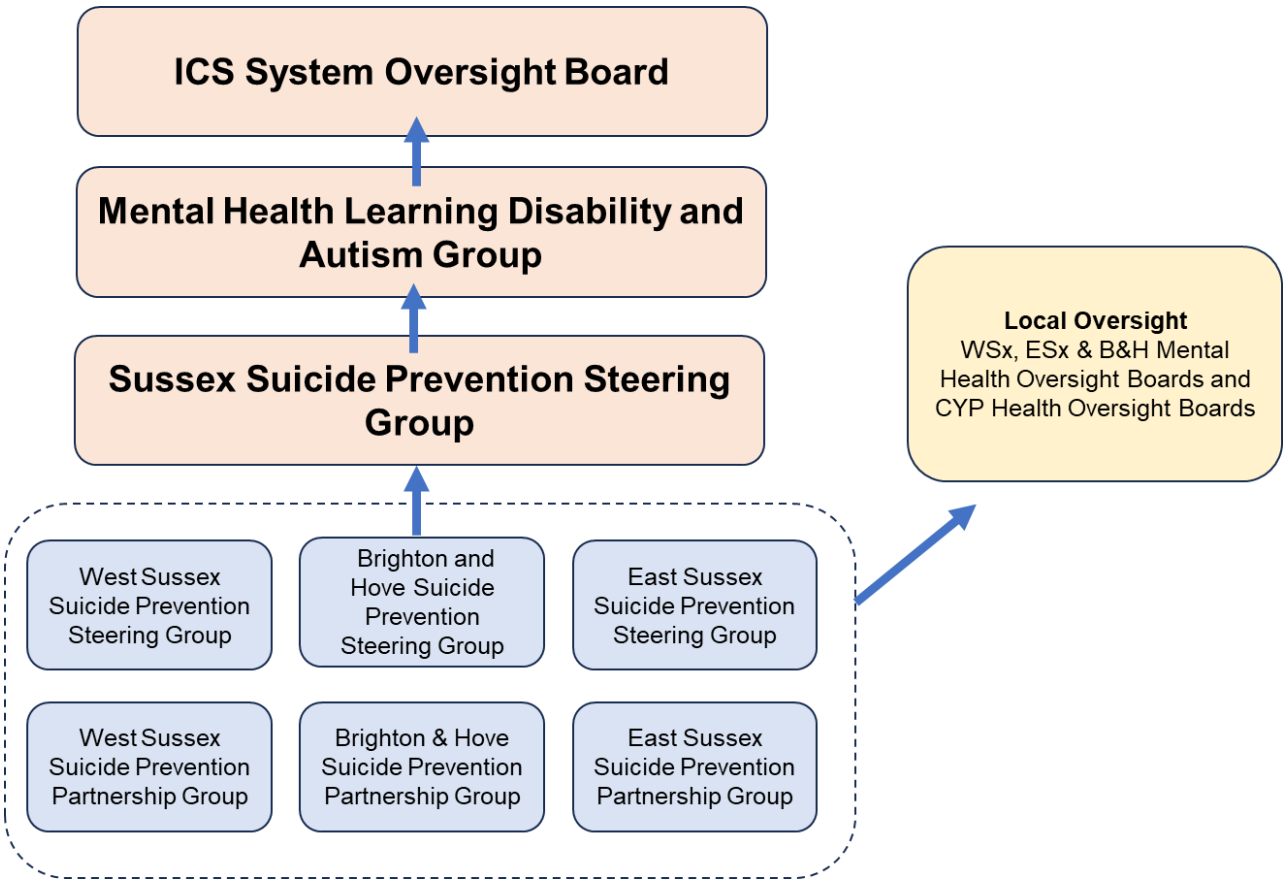
The need to develop local plans that engage a wide network of stakeholders was established in the government's national strategy for England, '*Preventing suicide in*

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.

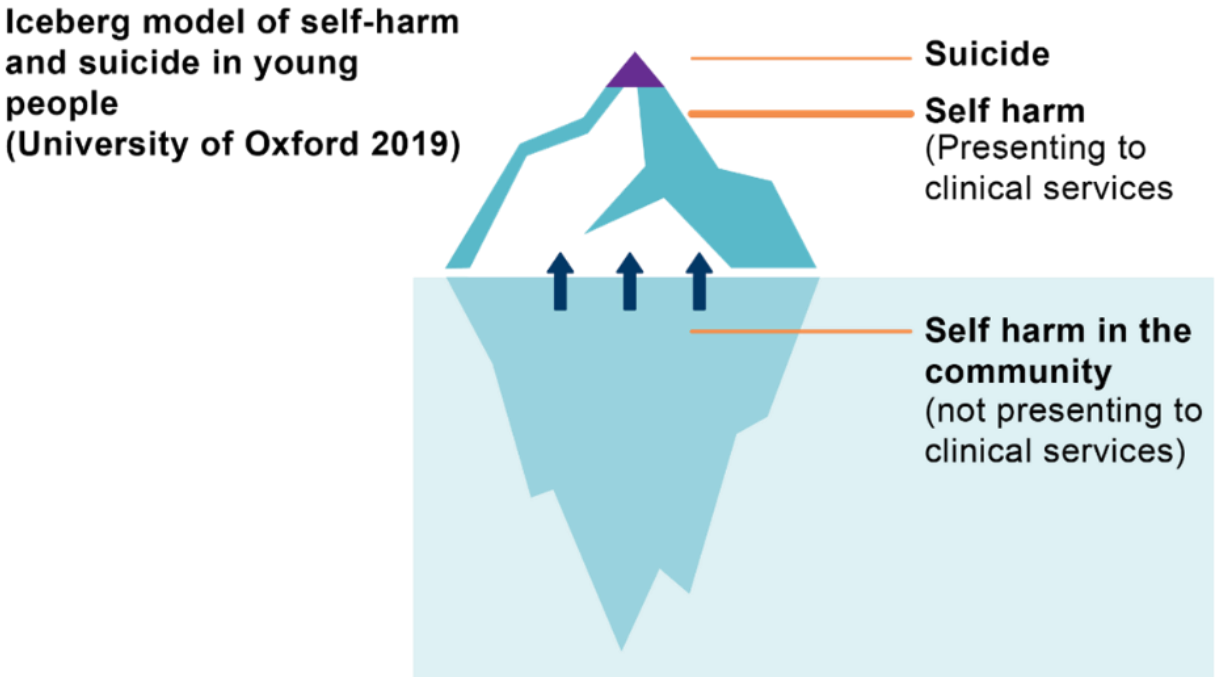
Men make up over 90% of the prison population[27].

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:

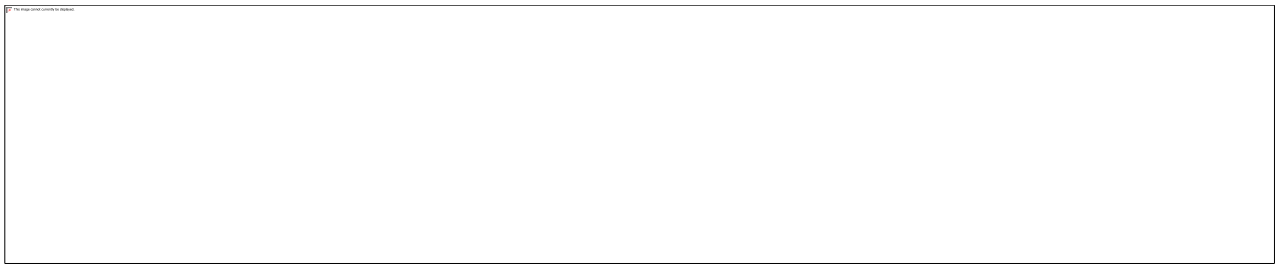
'Iceberg model': People with a history of self-harm



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:



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

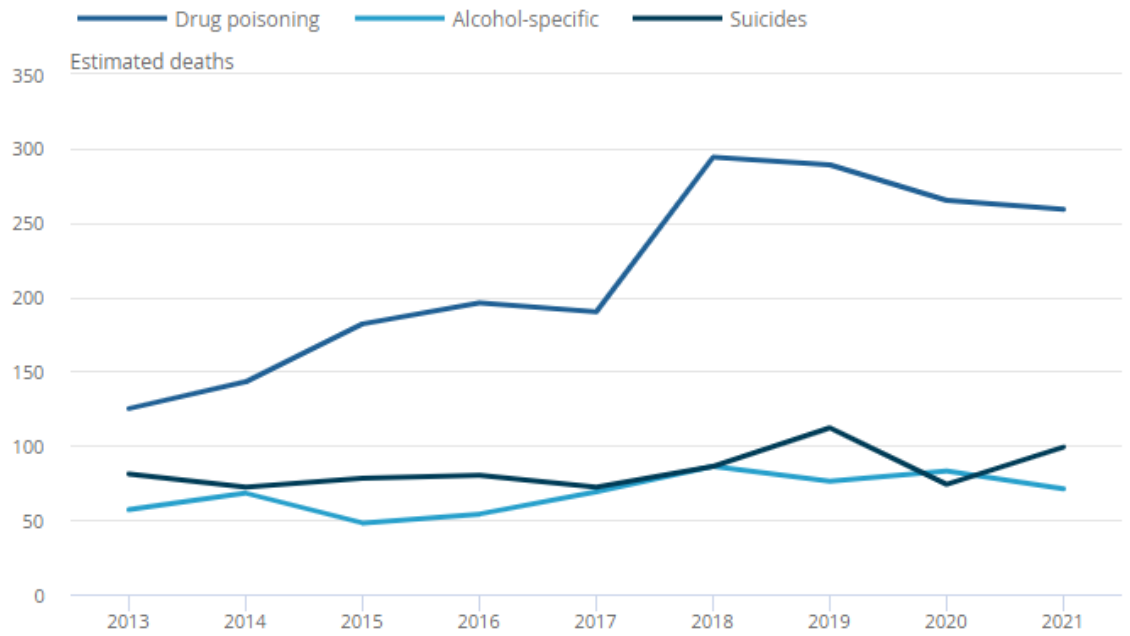
There is increasing evidence of the relationship between harmful gambling and suicide, including in younger people[70]. Although reasons for suicide can be complex, we do know that gambling can be a dominant factor without which the suicide may not have occurred. Action therefore needs to be taken to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

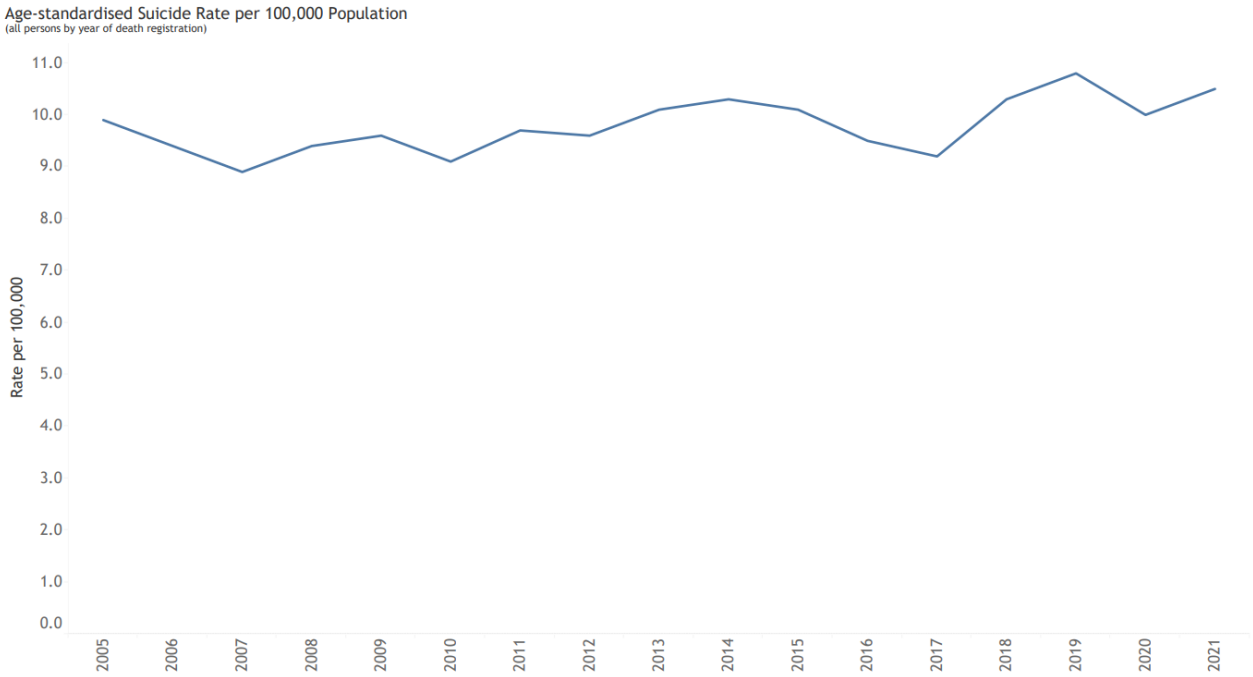
We strongly encourage all employers to have adequate and appropriate support in place for employees, such as people trained in mental health first aid, mental health support and suicide prevention awareness. Employers should also encourage employees to take the time to look after their mental health,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

7.0 Data

7.1 The National Picture incl. National Data:

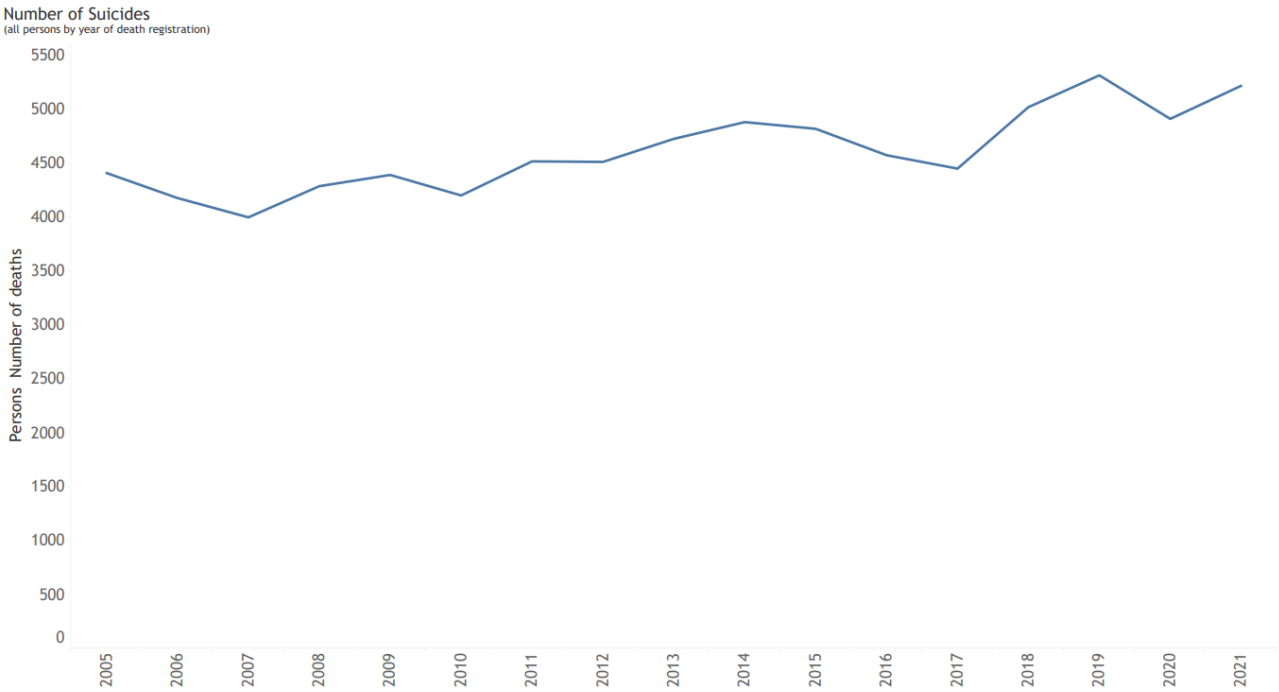
Between 2013 and 2018 suicide rates in England had been steadily reducing and although now rising again are low in comparison to those of most other European countries. Prior to the Covid-19 pandemic there were already concerns about the rising rate of suicide in 2018 and 2019 (see **Figures 1 and 2**). 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

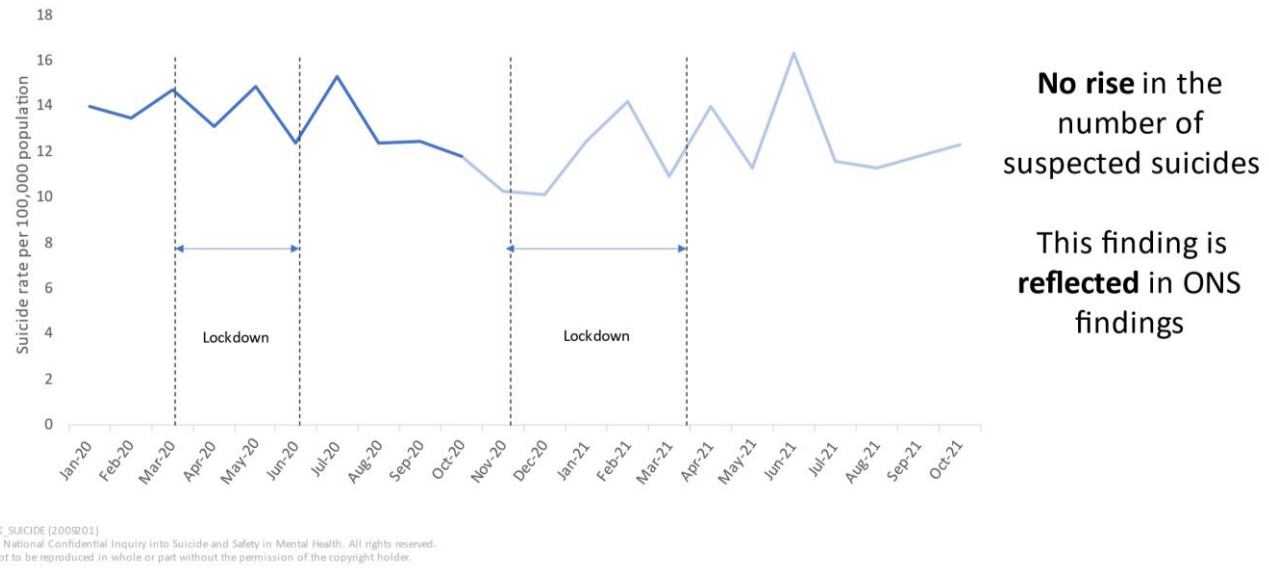
Collective efforts to improve patient safety led to a 35% fall in suicides in mental health inpatient settings in England between 2010 and 2020[101].

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



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

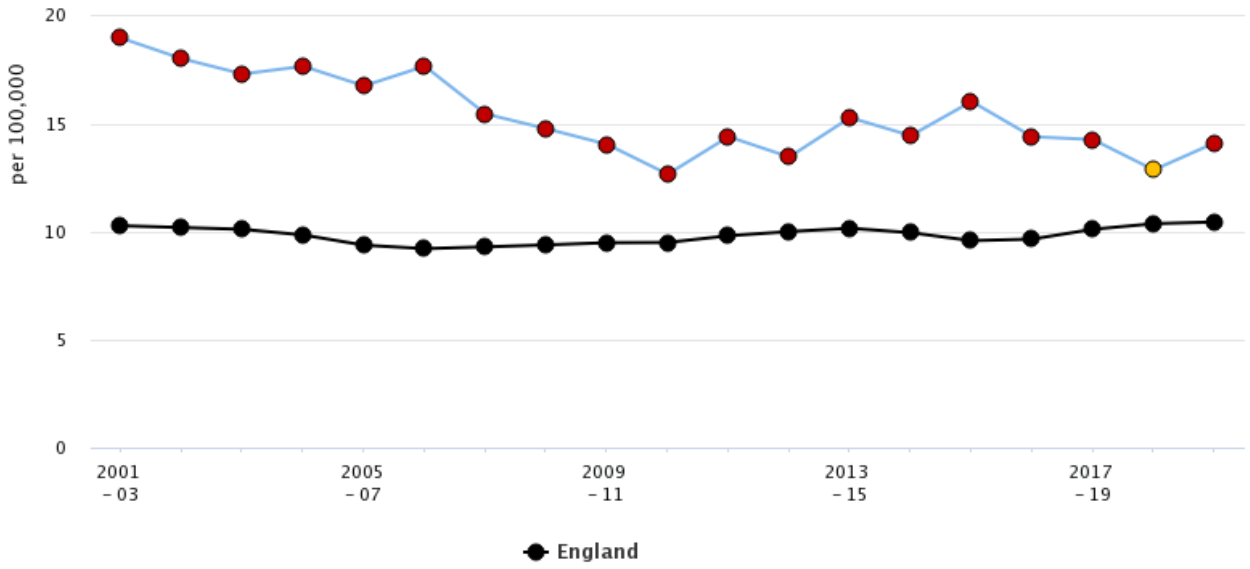


Figure 5: Suicide rate (Persons) for East Sussex

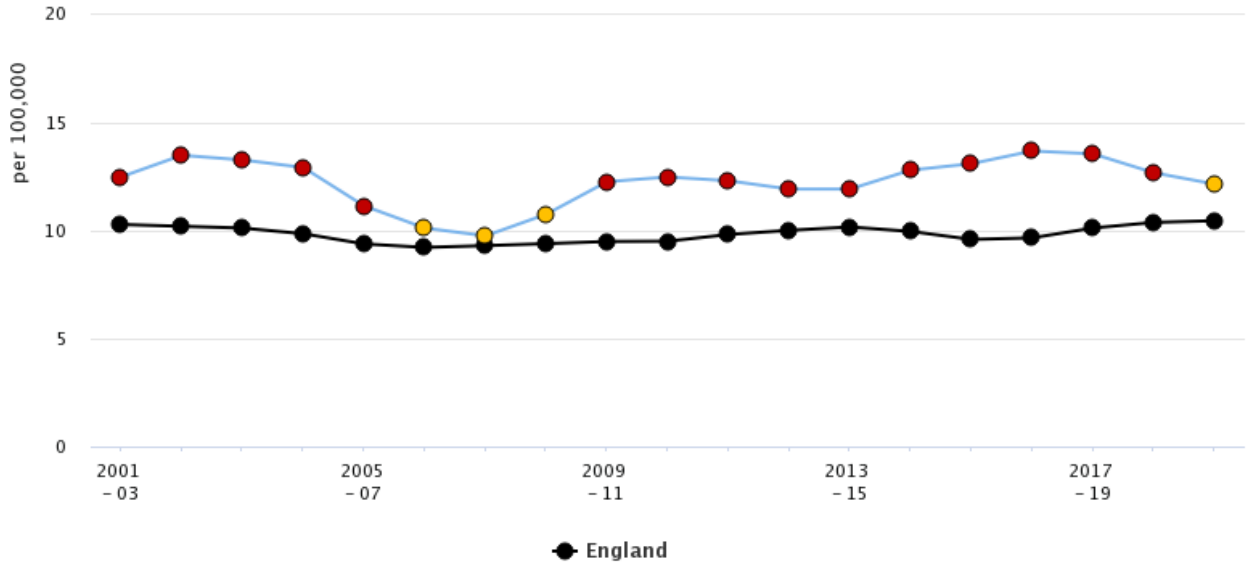
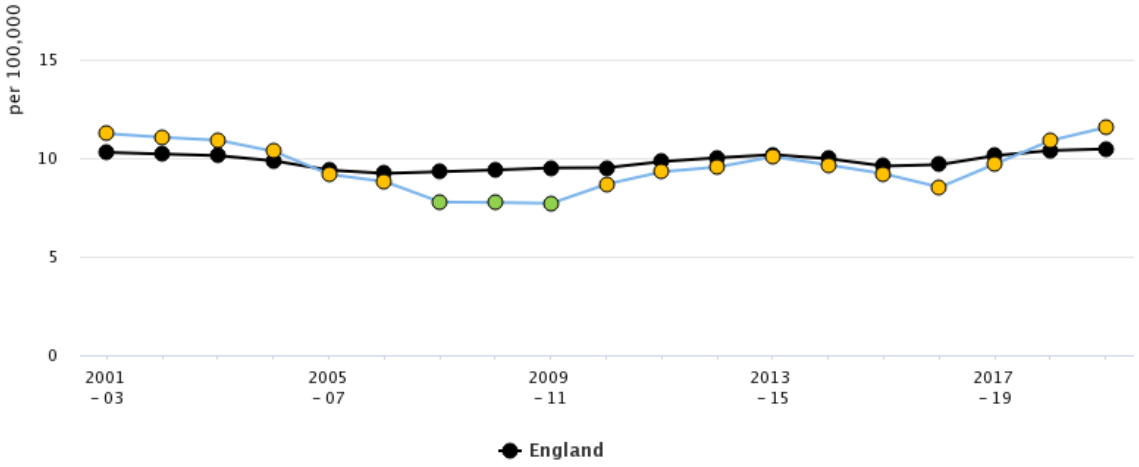


Figure 6: Suicide rate (Persons) for West Sussex



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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- Arsenault-Lapierre G, Kim C, Turecki G. Psychiatric diagnoses in 3275 suicides: a meta-analysis. BMC Psychiatry [Internet]. 2004 Nov 4 [cited 2016 Dec 1];4:37. Available from: ncbi.nlm.nih.gov
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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)
- Understanding Suicide Risk in Autistic Adults: Comparing the Interpersonal Theory of Suicide in Autistic and Non-autistic Samples | SpringerLink
- 'People like me don't get support': Autistic adults' experiences of support and treatment for mental health difficulties, self-injury and suicidality - PMC (nih.gov)
- Is Camouflaging Autistic Traits Associated with Suicidal Thoughts and Behaviours? Expanding the Interpersonal Psychological Theory of Suicide in an Undergraduate Student Sample | Journal of Autism and Developmental Disorders (springer.com)
- "We Have to Try to Find a Way, a Clinical Bridge" - autistic adults' experience of accessing and receiving support for mental health difficulties: A systematic review and thematic meta-synthesis - ScienceDirect
- Reports | MBRRACE-UK | NPEU (ox.ac.uk)
- NHS England » Perinatal mental health
- Risk of suicide after diagnosis of severe physical health conditions: A retrospective cohort study of 47 million people - PubMed (nih.gov)
- Contacts with primary and secondary healthcare prior to suicide: case–control whole-population-based study using person-level linked routine data in Wales, UK, 2000–2017 | The British Journal of Psychiatry | Cambridge Core
- Suicide prevention and the cost of living crisis - Money and Mental Health
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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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East Sussex
County Council

East Sussex Suicide Prevention Framework and Action Plan

2024-27

Contents

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1.Introduction

Suicide is defined in this report as 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]. 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, it is of the utmost importance that we do all we can to reduce this number as far as possible. 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[3].

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 for some time.

On 11th September 2023, the government published its new national strategy, '*Suicide prevention in England: 5-year cross-sector strategy*, and associated '*Suicide prevention strategy: action plan*'. This updates the previous five-year plan first published in 2012. The government subsequently published 5 progress reports, the last in March 2021.

1.1 Sussex Suicide Prevention Strategy and Action plan (2024-27)

The development of the pan-Sussex strategy began late 2022 and included two main areas of work,

- a review of the latest evidence, including academic research, government policy, public health guidance, and national and local data
- an engagement exercise with key stakeholders from the Sussex Suicide Prevention Partnership in summer 2022, where views were sought on seven proposed action areas. Groups and individuals consulted included community and voluntary sector groups, NHS, Police and local authorities.

The Strategy incorporates evidence of existing priorities and looks at areas where there is increasing evidence, rising concern and new national priorities including: online harms, economic adversity, people who identify as LBGTQ+, trends in children and young people, people who are neurodivergent, domestic abuse and pregnant women. [4]

1.2 East Sussex Suicide Prevention Framework and Action Plan 2024-2027

Work to develop the new East Sussex suicide prevention framework and action plan commenced during summer 2023. It was developed with the help of the East Sussex Suicide Prevention Steering Group and will be reviewed annually. The purpose of the document is to provide a framework and plan for action for multi-agency partners in East Sussex to work together to prevent suicides.

The East Sussex framework and plan should be considered alongside the Sussex Suicide Prevention Strategy and Action Plan (2024-2027), which provides further data and detail of what is effective in preventing suicide. The two documents together are designed to ensure an aligned approach locally and Sussex-wide.

Our East Sussex action plan (Sec.7) highlights the range of strategic approaches, programmes and projects at population level that will help contribute to delivering the ambitions of the Sussex Suicide Prevention Strategy and address local challenges. Where indicated, the plan details actions that will be tackled at a pan-Sussex level, such as surveillance, communications and training.

A significant local challenge for East Sussex is the continuing high level of completed suicides occurring at our coastal cliffs, primarily at Beachy Head. The majority of people completing suicide there travel from out of county, and so options to take 'upstream' preventative action are more limited. A programme of preventative work continues and is led by Public Health.

2. Our Vision

The aim of this framework is to reduce the risk of suicide in East Sussex.

Aligned with the vision of the Sussex Suicide Prevention Strategy and Action Plan (2024-2027), East 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.

2.1 Our Approach

Our approach focuses on the eight key areas outlined in the national strategy:

1. ***Improving data and evidence*** to ensure that effective, evidence-informed and timely interventions continue to be developed and adapted.
2. ***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.
3. ***Addressing common risk factors linked to suicide at a population level*** to provide early intervention and tailored support.
4. ***Promoting online safety and responsible media content*** to reduce harms, improve support and signposting, and provide helpful messages about suicide and self-harm.
5. ***Providing effective crisis support across sectors*** for those who reach crisis point.
6. ***Reducing access to means and methods of suicide*** where this is appropriate and necessary as an intervention to prevent suicides.
7. ***Providing effective bereavement support*** to those affected by suicide.
8. ***Making suicide everybody's business*** so that we can maximise our collective impact and support to prevent suicides.

3. Governance and Accountability

This framework and action plan is monitored and overseen by the East Sussex Suicide Prevention Steering Group (multi-agency) who report into the East Sussex Mental Health Oversight Board and the Pan-Sussex Suicide Prevention Steering Group.

In addition, updates will be shared, as required, with the Health and Wellbeing Board, the multi-agency Children and Young People Health Oversight Board and Children and Young People Mental Health and Emotional Wellbeing Partnership Group.

Appendix 1 presents this information in diagrammatic form.

Governance and accountability structures will be regularly reviewed and updated where required, as we progress implementation of our action plan across the Council and with partners.

In East Sussex, due to the continuing high number of deaths at coastal locations, Public Health East Sussex lead on a related programme of work which is also multi-agency in nature and reports when required to the fora mentioned above.

4. Groups or individuals who have increased 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.

4.1 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[5].

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[6].

A study published in 2021 of men aged 40 to 54 who died by suicide in the UK[7] 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[8].

4.2 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[9]. 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[10] 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.

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[11]

- 52% of suicides in under 20's reported ***previous self-harm.***
- ***Events in childhood*** impact negatively on health in adulthood (physical and mental health), and 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***[12]
- 6% of suicides in under 20's occurred in ***lesbian, gay, bisexual, and transgender (LGBTQI+) 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***[13].
- ***Physical health condition*** were identified in 30% of deaths by suicide in those under the age of 20[14]
- ***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[15].

While ONS statistics suggest that higher education students in England have lower suicide rates[16] 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.

4.3 Family and friend carers

Male and female carers, who look after the people who are sick, elderly and disabled have a higher-than-average risk of suicide[17]. There are an estimated 90,405 unpaid carers of all ages in West Sussex, representing 10.4% of the total population (similar to the England). Around 9 million people in the UK provide unpaid care to family or other relatives.

4.4 People with pre-existing mental illness

Eighty to ninety percent of people who attempt/die by suicide have a mental health condition, but not all are diagnosed.[18] There is approximately an 8-fold increase in risk of suicide for people under mental health care for mental illness[19]. In the case of depression, on average, the risk of suicide is about 15 times higher than the average for the general population[20].

People known to be in contact with mental health services represent around 27% of all deaths by suicide in England[21] – 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[22]. 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.

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[23]
- personality disorders, who accounted for 11% of all patient suicides in England between 2010 and 2020 (and this figure is increasing) [24]
- schizophrenia and other delusional disorders, who accounted for 16% of all patient suicides in England between 2010 and 2020[25]
- eating disorders, where one-quarter to one-third of people diagnosed with anorexia nervosa and bulimia nervosa have attempted suicide. [26]

4.5 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.

Whilst suicide is more common in men, nationally self-harm is more common in women.[27] Approximately 50% of people who die by suicide have previously self-harmed[28][29]. 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. While unemployment was a high-risk factor, financial problems as a motivation for self-harm were higher in the least deprived areas[30].

Self-harm has high levels of underreporting[31]. As a result, accurate prevalence figures are difficult to determine precisely, with statistics largely focused on those who present to hospital or primary care[32]. These statistics show that the rates of self-harm in children and young people have been increasing over recent decades across a number of comparable countries.

Estimates for the prevalence of self-harm amongst children and young people in England range between approximately 13% and 20%. For example, analysis of data from the Health Behaviour in School-aged Children (HBSC) survey for England (2014) found 22% of 15 year olds to report that they had ever self-harmed, with nearly three times as many girls reporting that they had self-harmed (32%) compared to boys (11%).

A recent East Sussex needs assessment of self-harm in children and young people concluded the following,

- Around a third of secondary school age children report having ever intentionally hurt themselves
- Around 1 in 20 secondary school age children report self-harming regularly.
- Self-harm behaviours are higher in females and increase with age. More males are seen with increasing age.
- For those attending hospital for self-harm, drug overdose or self-poisoning are the main methods of harm. Other methods of harm are higher in males and also in under 15s.
- For those attending hospital, paracetamol is the most common type of overdose followed by antidepressants.
- Self-harm increases with increasing levels of deprivation.
- Repeat hospital attendance for self-harm has been higher in recent years and is higher in females.
- A&E attendances due to self-harm remain fairly stable.
- East Sussex has an increasing and significantly higher rate of self-harm admissions

than England and the South-East, and the most recent data for 2020/21 shows East Sussex has the highest rate in Sussex.
- Within East Sussex, self-harm ambulance call-outs and admissions are highest in Hastings with admissions on an upward trend.
- Available data suggests that the prevalence of self-harm is not increasing. Survey data of secondary school pupils suggests the prevalence of regular self-harming behaviours in 2020/21 is similar to rates in 2017, and A&E attendances appear to be fairly stable. However, the increase in self-harm admissions and repeat self-harm clearly indicates that the severity of self-harming is getting worse.

4.6 LGBTQI+

People from the LGBTQI+ community are increasingly identified as having higher risk of suicide. Nationally 6% of suicides in under 20's occurred in lesbian, gay, bisexual, and transgender (LGBT) people of whom one quarter had been bullied[33]. 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[34].

4.7 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?" [35]

4.8 Neurodivergence

Neurodivergence is the term used for *people whose brains function differently in one or more ways than is considered* standard or typical[36]. The term neurodivergence includes Autism and attention-deficit/hyperactivity disorder (ADHD) conditions.

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.

People with neurodivergent disorders may face 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. They may also face barriers in gaining support to access employment or to remain in employment.

Evidence suggests autistic people, including autistic children and young people[37], may be at a higher risk of dying by suicide compared with those who are not autistic[38]. Undiagnosed or late-diagnosed autism may be a preventable risk factor for suicide[39] 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[40], barriers to accessing support[41], pressure to 'camouflage' or 'mask' autism[42] (for example, concealing particular traits that are common in autistic people) and feelings of not belonging[43]. Autistic people report difficulties in accessing mental health support[44] because they have an autism diagnosis, are awaiting autism assessment or because of a lack of reasonable adjustments to services.

There is emerging evidence that ADHD is also significant indicator for suicide risk[45]. Evidence also indicates that neurodivergent people are over-represented in the other high-risk groups - homeless, substance misuse and problem gamblers.

4.9 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[46]. The impact 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[47] and is linked to suicide.

4.10 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)[48]. 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 and those with shorter lengths of service. Contrary to popular perceptions, the study also found that those who have served in a conflict had a reduced risk of suicide.

4.11 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.[49] 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.

4.12 People with Physical illness

Evidence suggests that a diagnosis of a severe physical health condition may be linked to higher suicide rates[50]. Evidence from NCISH suggests that over half of men aged 40 to 54 who died by suicide had a physical health condition[51].

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[52]. Over 40% of middle-aged men have been in contact with primary care services[53] 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.

5.13 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[54]

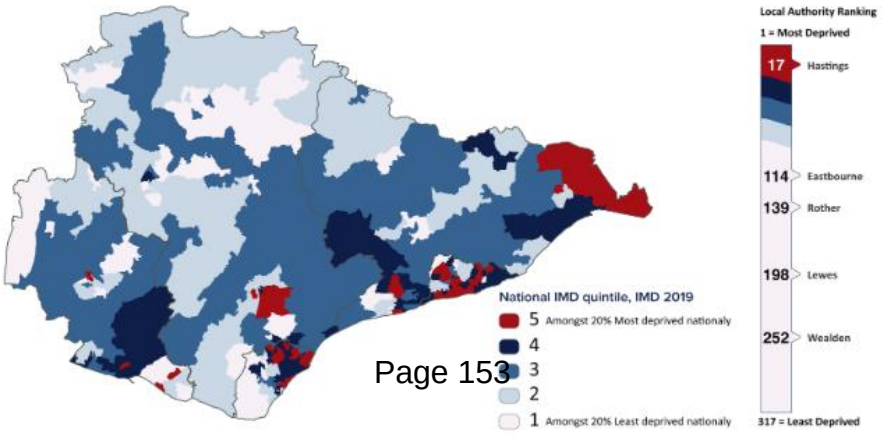
Gypsy Roma Traveller communities - the evidence for Gypsy, Roma, Traveller and nomadic communities is limited but suggests that the suicide rate for Irish Traveller women is six times higher than the general population, and seven times higher for Irish Traveller men.[55]

5. Risk factors linked to suicide at population level

5.1 Socio-economic deprivation

Suicide rates are higher among men and women living in the most deprived areas of England. Middle-aged men 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)[56].

East Sussex is the 5th most deprived of the 26 county councils, although deprivation varies significantly within the county, with Hastings being the 17th most deprived of the 317 local authorities nationally, and Wealden being the 65th least deprived.



5.2 Occupation and unemployment

Analysis of 2011[57] 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[58].

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.

People with a mental health condition are three times more likely to have a 'long term' period of sickness, and this can reduce the likelihood of them returning to work and increase their likelihood of future unemployment. Whilst there are more people at work with mental health conditions than ever before, 300,000 people with a long-term mental health problem lose their jobs each year, a much higher rate than people with physical health conditions[59].

Unemployment is a key risk factor for all, particularly men between 40 and 60, along with other causes including unmanageable debt, and social isolation[60]. In the last recession there was a 1.4% rise in suicide rates for every 10% increase in unemployment in men[61].

People experiencing serious mental health problems are also less likely to be in work than those without them. The gap in employment rate between people in contact with secondary mental health services and people who are not is 69.1% in East Sussex, which is marginally worse than the England gap at 67.2%[62]

The gap in the employment rate between those with a long-term health condition and those without in East Sussex is 9.5%, this is slightly lower than that of England at 10.6%[63]

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

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[64]. 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, with some feeling suicidal[65].

People amongst the most deprived 20% of society are more than twice as likely to die from suicide than the least deprived 20%[66].

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[67]. 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[68]. Men in mid-life were particularly vulnerable.

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.

There is increasing evidence of the relationship between harmful gambling and suicide, including in younger people[69]. 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.

5.4 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[70]. There is increasing recognition that those significantly affected by suicide extend beyond those known to the deceased, including witnesses, frontline professionals and others working in suicide prevention.

5.5 Domestic abuse

Since the 2012 national strategy, more evidence of a link between domestic abuse and suicide[71] has emerged. Research on intimate partner violence, suicidality and self-harm[72] 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[73] 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[74].

5.6 Substance misuse

People who misuse 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].

5.7 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]. 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].

5.8 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[88].

People who are homeless have a higher proportion of mental disorders than people with stable accommodation, particularly psychotic illness, personality disorders and substance misuse[89]. 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[90]. This rises to 8 out of 10 people who are sleeping rough.

6.Data

6.1 National Data

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[91].

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[92].

Of the suicides recorded in England in 2021, just under 74% were completed by men, at 15.8 per 100,000 compared to 5.5 per 100,000 women.[93] In recent years, nationally 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 cartNational 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[94].

6.2 East Sussex Profile

East Sussex has a population of approximately 558,900. The rate of suicides in East Sussex of 12.1 per 100,000 people (approximately 68 people per year) exceeds the England average of 10.4 but is between other parts of Sussex (Brighton and Hove,14.1 and West Sussex, 11.5). These rates are measured over a 3 year period, 2019 – 2021[95]. The chart below compares the East Sussex rates with England and local authority areas in the South-East.

Chart 1: Comparison of East Sussex suicide rates with England, the Southeast region and local authorities in the South-East[96]

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 are far higher than women, accounting for approximately 70% of deaths, which is similar to England as a whole. The suicide rate in East Sussex has consistently tracked higher than the national average See chart 2. Of the 5 district and boroughs in East Sussex, rates are highest in Eastbourne (19.6), and the lowest is Rother (9.4). See chart 3.

Chart 2. Suicide rate (persons) 2001-2021. East Sussex.

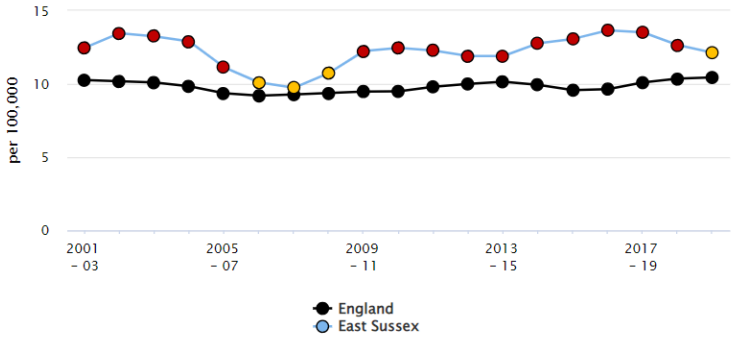


Chart 3. Suicide rate (persons) 2001-2021. East Sussex District and Boroughs 2019-21

Area	Value	95% Lower CI	95% Upper CI
England	10.4	10.3	10.6
East Sussex	12.1	10.3	14.0
Eastbourne	19.6	14.6	25.9
Hastings	11.9	8.0	17.1
Lewes	10.7	7.2	15.4
Wealden	9.9	7.1	13.3
Rother	9.4	5.8	14.3

Source: Office for National Statistics

7. Suicide Prevention Action Plan 2024-2027: Year 1 Actions

1. Improving data and evidence to ensure that effective, evidence-informed and timely interventions continue to be developed and adapted.		
Action	**Success measures / Outputs and outcomes**	**Lead Agencies**
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 suicide, including contagion.	RTS monthly reporting Systems in place to identify clusters ***Pan-Sussex Collaboration***	Public Health (East Sussex, West Sussex, Brighton and Hove)
Development of RTS dashboard to include self-harm and drug related death data.	New system capacity to monitor self-harm attendance/admissions and drug related deaths. ***Pan-Sussex Collaboration***	Public Health (East Sussex, West Sussex, Brighton and Hove)
2. 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		
Action	**Success measures / Outputs and Outcomes**	**Lead Agencies**
Improving mental health of men, through • Men in Mind Project- Training and Skills Programme • VSCE Mental Health Network – Insights gathering • FE/College – future workforce project	• A successful programme, informed by ongoing evaluation • A clear understanding of how local communities and VSCE organisations can be supported to develop more projects to support mens' mental health. • The development of a college based educational programme to	Public Health East Sussex

	promote mental health of young men entering male dominated workplaces.	
Reducing the prevalence and impact of self-harm in children and young people through, • Implementing the recommendations of the East Sussex Children and Young People Self-Harm Needs Assessment	Formation of CYP Self-harm Task and Finish Group reporting to the CYP Mental Health and Emotional Wellbeing Partnership Group.	CYP Mental Health and Emotional Wellbeing Partnership Group, East Sussex County Council (ESCC)
Roll out of the Sussex Toolkit for Unexpected Deaths in Schools	Extend local training to support promotion and implementation of the toolkit. ***Pan-Sussex Collaboration***	Education East Sussex, ESCC
Don't Brush it Under the Carpet – MH Campaign for older peoples mental health	Successful campaign launched Autumn/Winter 2023 ***Pan-Sussex Collaboration***	Sussex Partnership NHS Foundation Trust
Supporting the mental health of pregnant women and new mothers through, • Family Hub Programme and Start for Life Offer – Parents in Mind (PIM) peer support services for women and non-birthing partners • Effective pathways of support for peri-natal mental health problems	• Successful evaluation of PIM (mothers) and commencement of PIM (fathers) • Multi-agency pathway review	Children Services (Early Help) and Public Health, ESCC

3. Addressing common risk factors linked to suicide at a population level to provide early intervention and tailored support.		
Action	**Success measures / Outputs and outcomes**	**Lead Agencies**
Establishment of 'stewardship approach' to ***tackling loneliness and social isolation***, through the 'Connecting People and Places' project. Annual Public Health Report 2022/23 - Connecting People and Places | (eastsussexjsna.org.uk)	Commencement of stewardship group and engagement activity with VCSE, local authority and NHS partners.	Sussex Community Development Association (SCDA) and Public Health, ESCC
Ongoing work of the Multiagency Financial Inclusion Steering Group (MFISG) to support to those experiencing financial stress and vulnerability, including • Up-to-date central 'cost-of-living' support web page • a 'plan on a page approach' to connect financial inclusion and mental health networks, to better understand the impact of mental health on financial stability (and vice versa).	• Widely available resources promoted through multiple agencies and staff training • Completion of network and engagement project to identify opportunities for action by the MFISG.	Adult Social Care and Health (ASCH), ESCC
Undertake a 'gambling heath needs assessment', to identify opportunities for harm avoidance and reduction.	Publication of needs assessment and a plan for implementing recommendations.	Public Health East Sussex
Ongoing implementation of the East Sussex Alcohol Harm Reduction Strategy 2021-26. • Establishment of Alcohol Care Team	• Commencement of secondary prevention service aimed at	Public Health East Sussex

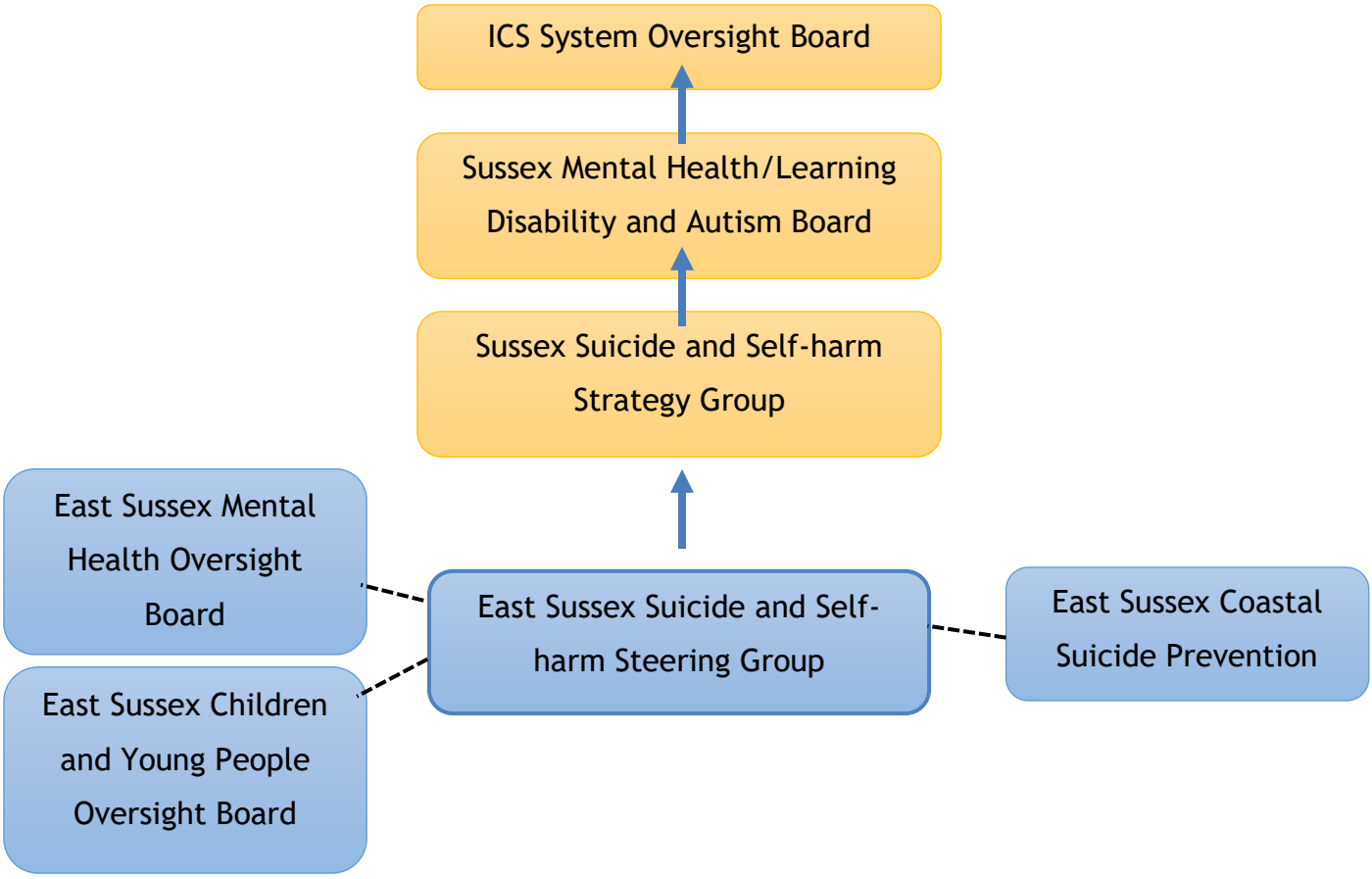
• Reducing supply in targeted areas (licensing and enforcement)	those attending hospital due to risky levels of drinking. • Reduce proliferation in alcohol selling outlets and licensing hours, in areas with higher deprivation and alcohol harm	
Supporting the aims of the East Sussex Safer Communities Partnership Plan through the prevention of domestic and sexual violence and abuse, against women and girls. • Theatre in Education Programme. Sexual relationships, harmful behaviours and consent	Successful education programme reaching Year 9 secondary school pupils (ages 13/14yrs), including curriculum component and teacher support.	Public Health East Sussex
4. Promoting online safety and responsible media content to reduce harms, improve support and signposting, and provide helpful messages about suicide and self-harm.		
Action	**Success measures / Outputs and outcomes**	**Lead Agencies**
Development of suicide prevention communications plan	• promote services to improve communities', individuals' emotional/mental wellbeing • promote mental health support services for people with escalating concerns • encourage communities' self-support *Pan-Sussex Collaboration*	Sussex Health and Care, Sussex Partnership NHS Foundation Trust, Public Health (East Sussex, West Sussex, Brighton and Hove)

Development of a 'Coastal Suicide Prevention Communications Plan'. Including. 1.Media Monitoring and Advice 2.Proactive Media 3.Resilience/good news network and stakeholder engagement 4.Communications resources 5.Digital landscape analysis and intervention	A multi-agency plan identifying opportunities for preventative action.	**Samaritans,** Public Health East Sussex
5. Providing effective crisis support across sectors for those who reach crisis point.		
Action	**Success measures / Outputs and outcomes**	**Lead Agencies**
Implementation of the Sussex Mental Health Urgent and Emergency Care Improvement Plan, including • Improving access to crisis cafes • Continued development of SHOUT Sussex text service for those needing 24/7 immediate support.	• Pilot of open access service in collaboration with Sussex Partnership Foundation Trust - Hastings and Brighton • Increased uptake of service (25% Dec 2022 to Dec 2023) *Pan-Sussex Collaboration*	Sussex Health and Care, Sussex Partnership NHS Foundation Trust VSCE mental Health Network/Southdown Housing
6. Reducing access to means and methods of suicide where this is appropriate and necessary as an intervention to prevent suicides.		
Action	**Success measures / Outputs and outcomes**	**Lead Agencies**

Continue with the Coastal Suicide Prevention Programme including, • Natural barriers feasibility study • Engagement Rangers/Ambassador Project • Communications strategy	• Completion of ecological survey • Commencement of project • Launch of strategy	Public Health East Sussex
Contribute to the ongoing work of the Safe Public Spaces (SPS) Network which seeks to share learning and good practice regarding locations with frequent suicides.	Continued membership and collaboration amongst national partners.	Public Health East Sussex
7. Providing effective bereavement support to those affected by suicide		
Action	**Success measures / Outputs and outcomes**	**Lead Agencies**
Work with partners to ensure continued support is available for those bereaved and affected by a suicide.	Development of common standard multi-agency operating procedure for identifying and supporting those affected. ***Pan-Sussex Collaboration***	Public Health (East Sussex, West Sussex, Brighton and Hove)
Deliver the 'Suicide Response & Prevention Workforce: Support & Supervision Project Workforce Wellbeing Project', which aims to establish support for non-frontline workers involved in suicide prevention work.	Completion of Phase 1: Exploration: Secure an academic partner to identify the target population, their needs and proposed interventions. ***Pan-Sussex Collaboration***	Sussex Health and Care, Public Health East Sussex
Undertake a Sussex wide 'bereavement needs assessment' [not limited to bereavement through suicide]	A report describing the nature and impact on residents and identify areas for improvement and development of support.	Public Health (East Sussex, West Sussex, Brighton and Hove)

	Pan-Sussex Collaboration	
8. Making suicide everybody's business so that we can maximise our collective impact and support to prevent suicides.		
Action	**Success measures / Outputs and outcomes**	**Lead Agencies**
Through the 'Men in Mind Project- Training and Skills Programme' encourage businesses, community interest groups and members of the public to play a part in recognising and helping people in difficulty.	A successful programme, informed by ongoing evaluation	Public Health East Sussex
Provide a free or low-cost training programme to anyone in a caring role, including VCSE staff and volunteers.	Full uptake of available training from a broad range of organisations and individuals.	Public Health East Sussex
Develop a sustainable approach to meaningfully involve those with lived experience across Sussex to develop and improve prevention activity* *(includes those who have made suicide attempts and those bereaved by suicide)	Pan- Sussex and East Sussex plans are implemented, through involvement of people with lived experience. *Pan-Sussex Collaboration*	Public Health (East Sussex, West Sussex, Brighton and Hove)

Appendix 1 - Governance structure East Sussex and Pan-Sussex



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East Sussex Health and Wellbeing Board Work Programme

Date of Meeting	Report
05 March 2024	East Sussex Health and Social Care Shared Delivery Plan (SDP) Programme - update report
	Mental Health Teams in Schools and school attendance
	Men's health work update and links to Makin it Happen and other programmes
16 July 2024	East Sussex Health and Social Care Shared Delivery Plan (SDP) Programme - update report
	Director of Public Health Annual report 2023/24
	Healthwatch Annual Report 2023/24
	Sussex learning from lives and deaths (LeDeR) Annual report 2023/24
26 September 2024	East Sussex Health and Social Care Shared Delivery Plan (SDP) Programme - update report
	Safeguarding Adults Board (SAB) Annual Report 2023-24
10 December 2024	East Sussex Health and Social Care Shared Delivery Plan (SDP) Programme - update report
	East Sussex Safeguarding Children Partnership (ESSCP) Annual Report 2023-24
	Joint Strategic Needs Assessment (JSNA) Update report
04 March 2025	East Sussex Health and Social Care Shared Delivery Plan (SDP) Programme - update report

East Sussex Health and Wellbeing Board Work Programme

TBC	NHS Health and Care Act (item from Cabinet agreeing MOU and formal participation in ICB).
TBC	Workshop meeting - to look at and agree milestones and Key Performance Indicators (KPIs) for monitoring on integrated health and social care partnership.
TBC	Children and Young People's Mental Health programme.