AGENDA

Meeting Health Committee

Date Thursday 12 January 2017

Time 2.00 pm

Place Committee Room 5, City Hall, The Queen's Walk, London, SE1 2AA

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www.london.gov.uk/mayor-assembly/london-assembly/health

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Members of the Committee

Dr Onkar Sahota AM (Chair)
Shaun Bailey AM (Deputy Chair)
Jennette Arnold OBE AM
Andrew Boff AM
Unmesh Desai AM

A meeting of the Committee has been called by the Chair of the Committee to deal with the business listed below.

Mark Roberts, Executive Director of Secretariat
Wednesday 4 January 2017

Further Information

If you have questions, would like further information about the meeting or require special facilities please contact: Rachel Greenwood, Committee Officer; telephone: 020 7983 4285; email: rachel.greenwood@london.gov.uk; minicom: 020 7983 4458

For media enquiries please contact: Lisa Lam; Telephone: 020 7983 4067; Email: lisa.lam@london.gov.uk. If you have any questions about individual items please contact the author whose details are at the end of the report.

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Agenda
Health Committee
Thursday 12 January 2017

1 Apologies for Absence and Chair's Announcements

To receive any apologies for absence and any announcements from the Chair.

2 Declarations of Interests (Pages 1 - 4)

Report of the Executive Director of Secretariat
Contact: Rachel Greenwood, rachel.greenwood@london.gov.uk, 020 7983 4285

The Committee is recommended to:

(a) Note the list of offices held by Assembly Members, as set out in the table at Agenda Item 2, as disclosable pecuniary interests;

(b) Note the declaration by any Member(s) of any disclosable pecuniary interests in specific items listed on the agenda and the necessary action taken by the Member(s) regarding withdrawal following such declaration(s); and

(c) Note the declaration by any Member(s) of any other interests deemed to be relevant (including any interests arising from gifts and hospitality received which are not at the time of the meeting reflected on the Authority's register of gifts and hospitality, and noting also the advice from the GLA's Monitoring Officer set out at Agenda Item 2) and to note any necessary action taken by the Member(s) following such declaration(s).

3 Minutes (Pages 5 - 34)

The Committee is recommended to confirm the minutes of the meeting of the Committee held on 29 November 2016 to be signed by the Chair as a correct record.

The appendix to the minutes set out on pages 9 to 34 is attached for Members and officers only but is available from the following area of the Greater London Authority's website: www.london.gov.uk/mayor-assembly/london-assembly/health

4 Summary List of Actions (Pages 35 - 44)

Report of the Executive Director of Secretariat
Contact: Rachel Greenwood, rachel.greenwood@london.gov.uk, 020 7983 4285

The Committee is recommended to note the completed and outstanding actions arising from its previous meetings.

5 Mental Health and Disabled and Deaf People (Pages 45 - 50)

Report of the Executive Director of Secretariat
Contact: Lucy Brant; scrutiny@london.gov.uk; 020 7983 5727

The Committee is recommended to:

(a) Agree the scope for its review into mental health and Disabled and Deaf people outlined at Appendix 1 to the report;

(b) Note the report as background for the discussion with invited guests and note the subsequent discussion; and

(c) Delegate authority to the Chair, in consultation with the Deputy Chairman, to agree any output from the discussion.

6 Health Committee Work Programme (Pages 51 - 52)

Report of the Executive Director of Secretariat
Contact: Lucy Brant; scrutiny@london.gov.uk; 020 7983 5727

The Committee is recommended to:

(a) Agree the proposals for the Health Committee work programme;

(b) Agree to use its meeting on 15 March 2017 for a discussion on issues relating to mental health support for ex-offenders and people released from prison; and

(c) Delegate authority to the Chair, in consultation with the Deputy Chairman, to agree the scope and terms of reference for the review of issues relating to this topic.

7 Date of Next Meeting

The next meeting of the Committee is scheduled for Wednesday, 15 March 2017 at 10.00am in the Chamber, City Hall.

8 Any Other Business the Chair Considers Urgent

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GREATERLONDONAUTHORITY LONDONASSEMBLY

Subject: Declarations of Interests

Report to: Health Committee	
Report of: Executive Director of Secretariat	**Date: 12 January 2017**
This report will be considered in public	

1. Summary

1.1 This report sets out details of offices held by Assembly Members for noting as disclosable pecuniary interests and requires additional relevant declarations relating to disclosable pecuniary interests, and gifts and hospitality to be made.

2. Recommendations

2.1 **That the list of offices held by Assembly Members, as set out in the table below, be noted as disclosable pecuniary interests[1];**

2.2 **That the declaration by any Member(s) of any disclosable pecuniary interests in specific items listed on the agenda and the necessary action taken by the Member(s) regarding withdrawal following such declaration(s) be noted; and**

2.3 **That the declaration by any Member(s) of any other interests deemed to be relevant (including any interests arising from gifts and hospitality received which are not at the time of the meeting reflected on the Authority's register of gifts and hospitality, and noting also the advice from the GLA's Monitoring Officer set out at below) and any necessary action taken by the Member(s) following such declaration(s) be noted.**

3. Issues for Consideration

3.1 Relevant offices held by Assembly Members are listed in the table overleaf:

[1] The Monitoring Officer advises that: Paragraph 10 of the Code of Conduct will only preclude a Member from participating in any matter to be considered or being considered at, for example, a meeting of the Assembly, where the Member has a direct Disclosable Pecuniary Interest in that particular matter. The effect of this is that the 'matter to be considered, or being considered' must be about the Member's interest. So, by way of example, if an Assembly Member is also a councillor of London Borough X, that Assembly Member will be precluded from participating in an Assembly meeting where the Assembly is to consider a matter about the Member's role / employment as a councillor of London Borough X; the Member will not be precluded from participating in a meeting where the Assembly is to consider a matter about an activity or decision of London Borough X.

Member	Interest
Tony Arbour AM	Member, LFEPA; Member, LB Richmond
Jennette Arnold OBE AM	Committee of the Regions
Gareth Bacon AM	Member, LFEPA; Member, LB Bexley
Kemi Badenoch AM	
Shaun Bailey AM	
Sian Berry AM	Member, LB Camden
Andrew Boff AM	Congress of Local and Regional Authorities (Council of Europe)
Leonie Cooper AM	Member, LFEPA; Member, LB Wandsworth
Tom Copley AM	
Unmesh Desai AM	Member, LB Newham
Tony Devenish AM	Member, City of Westminster
Andrew Dismore AM	Member, LFEPA
Len Duvall AM	
Florence Eshalomi AM	Member, LFEPA; Member, LB Lambeth
Nicky Gavron AM	
David Kurten AM	Member, LFEPA
Joanne McCartney AM	Deputy Mayor
Steve O'Connell AM	Member, LB Croydon
Caroline Pidgeon MBE AM	
Keith Prince AM	Member, LB Redbridge
Caroline Russell AM	Member, LFEPA; Member, LB Islington
Dr Onkar Sahota AM	
Navin Shah AM	
Fiona Twycross AM	Chair, LFEPA; Chair of the London Local Resilience Forum
Peter Whittle AM	

[Note: LB - London Borough; LFEPA - London Fire and Emergency Planning Authority. The appointments to LFEPA reflected above take effect as from 17 June 2016.]

3.2 Paragraph 10 of the GLA's Code of Conduct, which reflects the relevant provisions of the Localism Act 2011, provides that:

- where an Assembly Member has a Disclosable Pecuniary Interest in any matter to be considered or being considered or at

  (i) a meeting of the Assembly and any of its committees or sub-committees; or

  (ii) any formal meeting held by the Mayor in connection with the exercise of the Authority's functions

- they must disclose that interest to the meeting (or, if it is a sensitive interest, disclose the fact that they have a sensitive interest to the meeting); and

- must not (i) participate, or participate any further, in any discussion of the matter at the meeting; or (ii) participate in any vote, or further vote, taken on the matter at the meeting

UNLESS

- they have obtained a dispensation from the GLA's Monitoring Officer (in accordance with section 2 of the Procedure for registration and declarations of interests, gifts and hospitality – Appendix 5 to the Code).

3.3 Failure to comply with the above requirements, without reasonable excuse, is a criminal offence; as is knowingly or recklessly providing information about your interests that is false or misleading.

3.4 In addition, the Monitoring Officer has advised Assembly Members to continue to apply the test that was previously applied to help determine whether a pecuniary / prejudicial interest was arising - namely, that Members rely on a reasonable estimation of whether a member of the public, with knowledge of the relevant facts, could, with justification, regard the matter as so significant that it would be likely to prejudice the Member's judgement of the public interest.

3.5 Members should then exercise their judgement as to whether or not, in view of their interests and the interests of others close to them, they should participate in any given discussions and/or decisions business of within and by the GLA. It remains the responsibility of individual Members to make further declarations about their actual or apparent interests at formal meetings noting also that a Member's failure to disclose relevant interest(s) has become a potential criminal offence.

3.6 Members are also required, where considering a matter which relates to or is likely to affect a person from whom they have received a gift or hospitality with an estimated value of at least £25 within the previous three years or from the date of election to the London Assembly, whichever is the later, to disclose the existence and nature of that interest at any meeting of the Authority which they attend at which that business is considered.

3.7 The obligation to declare any gift or hospitality at a meeting is discharged, subject to the proviso set out below, by registering gifts and hospitality received on the Authority's on-line database. The on-line database may be viewed here: http://www.london.gov.uk/mayor-assembly/gifts-and-hospitality.

3.8 If any gift or hospitality received by a Member is not set out on the on-line database at the time of the meeting, and under consideration is a matter which relates to or is likely to affect a person from whom a Member has received a gift or hospitality with an estimated value of at least £25, Members are asked to disclose these at the meeting, either at the declarations of interest agenda item or when the interest becomes apparent.

3.9 It is for Members to decide, in light of the particular circumstances, whether their receipt of a gift or hospitality, could, on a reasonable estimation of a member of the public with knowledge of the relevant facts, with justification, be regarded as so significant that it would be likely to prejudice the Member's judgement of the public interest. Where receipt of a gift or hospitality could be so regarded, the Member must exercise their judgement as to whether or not, they should participate in any given discussions and/or decisions business of within and by the GLA.

4. Legal Implications

4.1 The legal implications are as set out in the body of this report.

5. Financial Implications

5.1 There are no financial implications arising directly from this report.

Local Government (Access to Information) Act 1985	
List of Background Papers: None	
Contact Officer:	Rachel Greenwood, Committee Officer
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E-mail:	rachel.greenwood@london.gov.uk

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GREATERLONDONAUTHORITY LONDONASSEMBLY

MINUTES

Meeting: Health Committee
Date: Tuesday 29 November 2016
Time: 10.00 am
Place: Chamber, City Hall, The Queen's Walk, London, SE1 2AA

Copies of the minutes may be found at:
www.london.gov.uk/mayor-assembly/london-assembly/health

Present:

Dr Onkar Sahota AM (Chair)
Shaun Bailey AM (Deputy Chair)
Andrew Boff AM
Unmesh Desai AM

1 Apologies for Absence and Chair's Announcements (Item 1)

1.1 Apologies for absence were received from Jennette Arnold OBE AM.

2 Declarations of Interests (Item 2)

2.1 The Committee received the report of the Executive Director of Secretariat.

2.2 **Resolved:**

That the list of offices held by Assembly Members, as set out in the table at Agenda Item 2, be noted as disclosable pecuniary interests.

3 Minutes (Item 3)

3.1 **Resolved:**

That the minutes of the meeting held on 19 October 2016 be signed by the Chair as a correct record.

4 Summary List of Actions (Item 4)

4.1 The Committee received the report of the Executive Director of Secretariat.

4.2 **Resolved:**

That the completed and outstanding actions arising from previous meetings of the Committee be noted.

5 Action Taken Under Delegated Authority (Item 5)

5.1 The Committee received the report of the Executive Director of Secretariat.

5.2 **Resolved:**

That the recent action taken by the Chair under delegated authority be noted, namely to agree, in consultation with the Deputy Chairman:

(a) The letter to the Mayor on Transport for London's role in promoting health in London, attached at Appendix 1 of the report; and

(b) That the meeting on 29 November 2016 be used for a discussion on suicide prevention in London.

6 Suicide Prevention in London (Item 6)

6.1 The Committee received the report of the Executive Director of Secretariat as background to putting questions on suicide prevention in London to the following invited guests:

- Amanda Coyle, Assistant Director, Health and Communities, Greater London Authority;
- Dr Paul Plant, Deputy Director, Public Health England (London);
- Professor David Mosse, Professor of Social Anthropology, University of London; Chair, Haringey Suicide Prevention Group;
- Jane Powell, Chief Executive, Campaign Against Living Miserably; and

- Dr Tamara Djuretic, Association of Directors of Public Health (London); and Public Health Consultant, Haringey.

6.2 A transcript of the discussion is attached at **Appendix 1**.

6.3 During the course of the discussion, Members requested the following additional information:

- Data on how the suicide rate in London compares with that of other UK cities;
- Details of the suicide prevention programme adopted in Londonderry, Northern Ireland; and
- Forward notice of the mental health strategy announcement due to be made by the Mayor in December 2016.

6.4 **Resolved:**

(a) That the scope for the Committee's review into suicide prevention in London, outlined at Appendix 1 to the report, be agreed;

(b) That the report, and subsequent discussion, and the commitments outlined at paragraph 6.3 above, be noted; and

(c) That authority be delegated to the Chair, in consultation with the Deputy Chairman, to agree any output from the discussion.

7 Health Committee Work Programme (Item 7)

7.1 The Committee received the report of the Executive Director of Secretariat.

7.2 **Resolved:**

(a) That the proposals for the Health Committee work programme, as set out in the report, be agreed;

(b) That it be agreed that the Committee's meeting on 12 January 2017 be used for a discussion on issues relating to disability and mental health; and

(c) That authority be delegated to the Chair, in consultation with the Deputy Chairman, to agree the scope and terms of reference for the review of issues relating to disability and mental health.

8 Date of Next Meeting (Item 8)

8.1 The date of the next meeting of the Committee was confirmed as Thursday, 12 January 2017 at 2.00pm in Committee Room 5, City Hall.

9 Any Other Business the Chair Considers Urgent (Item 9)

9.1 There were no items of business that the Chair considered to be urgent.

10 Close of Meeting

10.1 The meeting ended at 12 noon.

Chair _____ Date _____

Contact Officer: Rachel Greenwood, Committee Officer; telephone: 020 7983 4285; email: rachel.greenwood@london.gov.uk; minicom: 020 7983 4458

London Assembly Health Committee – 29 November 2016

Transcript of Item 6 – Suicide Prevention in London

Dr Onkar Sahota AM (Chair): That brings us to our discussion this morning. Can I please welcome Amanda Coyle, Assistant Director of Health and Communities at the Greater London Authority (GLA); Dr Paul Plant, Deputy Director of Public Health England (London); Professor David Mosse, Professor of Social Anthropology at the University of London and Chair of the Haringey Suicide Prevention Group; Jane Powell, Chief Executive of Campaign Against Living Miserably (CALM); and Dr Tamara Djuretic, Association of Directors of Public Health London and Public Health Consultant in Haringey. Thank you very much for coming this morning and for contributing to this discussion.

I may be directing my questions to some particular guests, but if you want to come in or want to make observations, please feel free to do so. If you feel you want add something to someone else's comments, then please do so.

Let me start off by asking the first question to Public Health England, Dr Paul Plant. Can you give us an overview of the current situation regarding suicide in London, what particular groups are most affected and how the situation varies between the boroughs in London?

Dr Paul Plant (Deputy Director, Public Health England (London)): Thank you for inviting us. We have just had a brief conversation between us. Just to go back one stage, we have to be really careful with the suicide numbers because the numbers are so small. We have to look at them in blocks of three years and averages.

The general picture is that rates are coming down. Although the numbers in the last three years have gone up, that has equalised with the population going up and the actual rates are coming down. London - compared nationally - has lower rates of suicide than anywhere else in the country on a regional level.

The rates are much higher in men. They are about three times as high in men. If you want a really broad overview, they are higher in the most deprived inner-city boroughs. The rank order of the boroughs may change over time but, basically, it is the inner London ones.

If you look at particular groups that are at high risk, it is those who have lived stressed lives, young people who may have been in care, people who have been victims of sexual or physical violence, people coming out of the armed forces, people with mental health problems. In essence, when you think about suicide and you think about people living stressed lives, the suicide itself is a tragedy for them and their families but, in a sense, it is the tip of an iceberg of a bigger set of issues and rates of mental distress.

Is that a broad enough picture just to get us going?

Dr Onkar Sahota AM (Chair): Also, there is a huge variation between the boroughs.

Dr Paul Plant (Deputy Director, Public Health England (London)): Yes.

Dr Onkar Sahota AM (Chair): You say that this could change from year to year?

Dr Paul Plant (Deputy Director, Public Health England (London)): Basically, the inner-city, inner London, deprived boroughs always have higher rates than the more affluent outer London ones. Like I said, if you wanted to say which were in the top five, the rank ordering may change marginally because the numbers are so small.

Dr Onkar Sahota AM (Chair): The recording of these suicides has a uniform system across London or do different boroughs record things differently?

Dr Paul Plant (Deputy Director, Public Health England (London)): No, it is a national system. To the extent to which there is under-reporting, I do not think there is any systematic bias in any part of London or any part of the country. There may be under-reporting for a number of reasons that you can think through, but I do not think there is any systematic bias in recording.

Dr Onkar Sahota AM (Chair): Any guest can come in, but do you think there has been any variation across London over the last ten years?

Dr Tamara Djuretic (Public Health Consultant, London Borough of Haringey): Are we asking the question whether there was a variation between the boroughs in the last ten years? I will give you a local example of the London Borough of Haringey, where I have my day job. In the last statistics, which were to 2014, Haringey had the highest suicide rate in London, which was at 11.8. When the new data came in looking at a different three years - and we have done quite a lot to reduce suicides - now it is the sixth highest in London. What we do see is that in a cohort of particular London boroughs including Camden, Islington, Hammersmith and Fulham, Haringey and Tower Hamlets - they might change in ranking but they usually are amongst the highest. In that sense, it has not changed as much in the last ten years. They tend to be the inner London, more deprived boroughs.

Professor David Mosse (Chair, Haringey Suicide Prevention Group): Just to add to that, the differences within boroughs are also striking and following a similar pattern. In Haringey there is a very clear east/west divide with consistently higher rates in Tottenham, for example, against the west of the borough areas like Crouch End and Highgate.

However, one thing in the recent suicide audit that was done: the second-highest borough for incidence in one particular period was a better-off area, Crouch End. Also, there was a slight increase in the number of female suicide as against men. Therefore, with the broad trends, although they are there, it is important to be alert to possible changes in those underlying patterns. Even nationally, there was a slight upturn in suicides among women, the reasons for which might be to do with the methods or access to methods. One needs to be open to the possible contexts and causes and not to, in a sense, be firmly settled on certain kinds of deprivation as the principal causes of suicide because we know it is the very complicated and tragic outcome of a wide range of circumstances and underlying issues.

Dr Onkar Sahota AM (Chair): All right. Dr Plant, we have been told that London has the lowest rate of suicide but can we, for the sake of the record, get some context of how it compares with other cities and regions of the United Kingdom (UK)? By saying it is has the lowest, can you put that in some sort of context, "These are the figures for Manchester; these are the figures for Glasgow"?

Dr Paul Plant (Deputy Director, Public Health England (London)): I do not have those with me. We just looked at London.

If you look at the pattern, though, you will always see higher rates in urban, deprived areas. Following that logic, you would get higher rates in Newcastle, Manchester and Liverpool just because of the urban context.

What is interesting about the London figures is that for other mental health problems London has a higher rate. What is interesting, if you want to tease this out, is why London has a lower rate of suicide but a higher rate of very serious mental health problems, for example. That is quite an interesting one for us in trying to understand why we have a lower rate of suicide but a general issue in the London population of problems with mental health.

I am sorry. I do not have specific data for the other cities.

Dr Onkar Sahota AM (Chair): Is this data available?

Dr Paul Plant (Deputy Director, Public Health England (London)): Yes, and we can certainly follow up and give you a briefing there.

Dr Onkar Sahota AM (Chair): Would you be kind enough to send it to us --

Dr Paul Plant (Deputy Director, Public Health England (London)): Yes.

Dr Onkar Sahota AM (Chair): -- later on, please, so that we can get it right for the record?

Jane Powell (Chair, Campaign Against Living Miserably): I have the regional rates here. London is 10.4 but the North West is 10.9, 10.8 and 11.6. It is lower than the North West but the North West has traditionally had quite high suicide rates.

If I may, ignoring three year averages, in 2015 the number of men taking their lives did go up by 119. In 2014 there were 424 deaths and in 2015 there were 543. The rate has gone up quite significantly in the last year.

The way that suicide is recorded is systematic, certainly, across the UK. However, there are many gaps. There is no routine collection of data about work, ethnicity or religion. If there were a number of people, say, from Eastern Europe taking their lives, it is really important that we have accurate data so that we can respond rapidly. At the moment, that data is not available rapidly. Elsewhere in the UK there are some trials to look at real-time recording and I think that would be really useful if there is, say, a spate of suicides in a particular area or that are related to each other to know more about that. At the moment, the systems are not there for that to happen and those systems could be there if there was the will.

The number of women taking their lives last year did go up slightly, too. We take near 2,000 calls from people within London, mainly men, each month. Yes, poverty, mental health problems and those kinds of issues are significant, but we take calls from bankers, calls from politicians and calls from across the community. It is not just about deprivation; it is also about stress and life going bad.

The thing that we feel we should point out is that most suicides are male and that there is an added barrier to men seeking help. The shame and embarrassment that as a man you need help is a real barrier to cross.

Dr Onkar Sahota AM (Chair): Thank you. Jane, if there is data you could share with us, it would be very helpful.

Andrew Boff AM: I was just wondering. It seems like there is a lot that is not being recorded and it does not sound like it would be too much of an effort to record those pieces of data.

Jane Powell (Chair, Campaign Against Living Miserably): Sometimes there is. If there is a body taken out of the Thames and someone has come down from Scotland or somewhere to take their life, it is very hard to ascertain whether he was in work and what his situation was. However, there should be an effort made.

I remember being approached by one of the Kurdish community some years back who was very concerned about the levels of suicide within that community, yet there was no way of telling how many Kurdish men had taken their lives. We know that suicidality travels with people. In areas and in countries where the suicide rate is very high, they are likely to have a high suicide rate, too. If we have people coming from countries with deprivation and where the suicide rate is high, it would be helpful to know which communities we should target.

Dr Tamara Djuretic (Public Health Consultant, London Borough of Haringey): I was just going to come in while we are talking about data with a clarification point. There is a difference with routinely collected data, which is slightly limited in terms of demographics, and then each locality can do a suicide audit, which is going back to the coroner's data and which again is not consistently complete but does give you more information in terms of specific communities. Each locality is recommended to do suicide audits every two to three years. They are extremely resource-consuming and it varies in how localities approach that, but the only agile way of informing suicide prevention plans is to have regular suicide audits, which would give you specific communities and specific trends. That is how we found out in Haringey that maybe the demographics are changing slightly.

Professor David Mosse (Chair, Haringey Suicide Prevention Group): Can I come in there on the coroner's records? The coroner's records really are the crucial source of information. The first thing is that of course coroner's courts are set up to reach a verdict or a conclusion as to whether it is a suicide, whether it is an open verdict, whether there is a narrative verdict or whether it is an accident. Which of those are included in the suicide data has a significant bearing on what the numbers look like.

The other thing is that coroners are tasked with reaching a verdict or a conclusion against criminal standards of proof. Their job is not to generate evidence and information for public health purposes. In the course of their inquiries they do generate that information, but it is not routinely and systematically collected, stored and catalogued to create databases that are accessible for public health planning purposes. Therefore, it is to some extent somewhat arbitrary and hit-and-miss as to whether particular information is available. It is only by - and this is what we are doing in Haringey - working directly with the coroner's records on a case-by-case basis and examining each and every one to look at the determinant factors and to find out about the identity, the background, the medical records and the history because this is not routinely available.

Andrew Boff AM: It is astonishing, is it not, that that is not available?

Professor David Mosse (Chair, Haringey Suicide Prevention Group): Yes, because that is crucial for generating the relevant data and intelligence for local suicide prevention planning, which is correctly now the emphasis.

Co-ordinating and ensuring consistency in the records kept by coroner's courts is a crucial part of the picture of developing effective audits. That audit that we have in Haringey is in some ways very unsatisfactory because we simply do not know. All we can say is that a certain proportion of people who died by suicide, for example, were in contact with secondary mental health services, of those for whom there is information

available, but it may only be 50% of cases for which the information is available or less. We do not have the whole picture.

This is the case in almost all cases except the few examples such as Durham and other places where there has been a systematic effort to generate real-time data on suicides that feeds directly into public health, maybe through the police, really even earlier, to ensure that the information is timely, accurate and available even before the inquests.

Andrew Boff AM: Can I just ask? Something you might be able to tell us about is the trend of teenage suicide rates perhaps over the last decade. Have we seen any change in that?

Dr Paul Plant (Deputy Director, Public Health England (London)): In the last three years, there has been an increase for 10-to-19-year-olds in London. I cannot remember the start year but, in that three-year period, it went from 10 suicides to 24. The numbers are so small but, yes, we have seen an increase in that age group.

Andrew Boff AM: Have any conclusions been come to as to why that might have happened?

Dr Paul Plant (Deputy Director, Public Health England (London)): If we go back, what we are trying to encourage - and we will come on to this - is each borough developing its own suicide plan. When we look at it, 24 cases is less than one per borough. We would not know that degree of specificity about why that was increasing. Strategically, we are more interested in more boroughs doing their own local work to target their own at-risk groups using that local data.

We are very worried about mental wellbeing in teenagers in the round and so we are doing work on trying to build resilience and that links into what the National Health Service (NHS) is doing in relation to child and adolescent mental health services. Yes, we are putting that pressure on there but, as for looking at 24 cases across London, we have not gone into that degree of detail.

Dr Tamara Djuretic (Public Health Consultant, London Borough of Haringey): I was just going to say that in each borough every death of a child under 18 years of age is looked at by a child death overview panel. They would look into more details that are confidential. Because of the rise in teenage suicides, London is having a workshop in mid-December 2016 to look at the particular reasons and trends across the boroughs and so we will have more details then.

Jane Powell (Chair, Campaign Against Living Miserably): Before addressing teenagers, the area and the rate where it is highest is in middle-aged men.

Coming back to teenagers, we do take thousands of calls a month from teenagers across the UK. About 20% to 30% will be from London. The reasons they call are exam stress, mental health concerns and breakups. What we see --

Andrew Boff AM: When you say "breakups"?

Jane Powell (Chair, Campaign Against Living Miserably): The first girlfriend dumping them. What we see, particularly with boys, is that it is their first breakup, they have exam stress and they are trying to prove themselves: their life has failed. We see that boys in every level of education fail more than girls do. What we are left with is boys who are failing at school, whose self-worth and self-esteem is based around very little and who are subject to huge hormones. When they have that first breakup, when there is anything going wrong in

their lives, they crumble. They feel that they cannot get or deserve any help and that there is something wrong with them.

It is really important that we do reach out to girls and boys, but the suicide rate amongst young boys is three times higher than it is amongst young girls. Given that 75% of all suicides are male, it is important that there is a gender aspect to any suicide prevention work.

Just to come back to David's [Mosse] point earlier about information, in Londonderry [Northern Ireland] and in parts of the UK now, the police will do real-time recording of suicides and so they will be the first to inform the family. That is the key point at which to identify other people who are going to be significantly more at risk to suicide. That will be the best mates, the friends and family, the grandparents. Suicide in the over-85s is very high. All of those people are at much higher risk to suicide.

A suicide prevention plan should include making sure that there is more than what is currently available - a booklet - to those people who have been bereaved by suicide. If your son has just hung himself and you have found him in his bedroom, your life has been blown apart and so have the lives of all of those people who knew that person. They are very highly at risk of suicide and, therefore, there should be something more than a booklet to help those people through.

Professor David Mosse (Chair, Haringey Suicide Prevention Group): Just to add to that, since this came up with the suicide rates among young people, a Manchester study on young suicides showed that among the various factors bereavement was important - in particular bereavement by suicide - as a significant risk factor in suicides and also among the very youngest categories.

On this whole question of support for those bereaved by suicide, support for the bereaved by suicide - because they are a particular at-risk group - was included as one of the key elements of the National Strategy for Suicide Prevention in 2012. There are important and excellent pilots that have been developed and Jane [Powell] has mentioned the work in Northern Ireland and the work in Durham.

However, by and large, this is an area of work - in other words, putting together effective "post-vention": that is to say support for those bereaved by suicide, putting in place community response plans after a suicide, ensuring that there is joined-up work with the police, who are often the first on the scene, linking people to the primary healthcare services and particular charitable services that are available for those bereaved - is really work that has hardly got off the ground in many areas of London. Of course, that is the case further afield as well. Perhaps there is more we should discuss about that in the course of the meeting.

Dr Onkar Sahota AM (Chair): We will pick this up, but let me get this absolutely clear. Is the suggestion being made that of course the records of the coroner's office are not ideal but there are some boroughs that do a suicide audit?

I work in the London Borough of Ealing as a doctor some of the time and I have audits when patients have unfortunately committed suicide and detailed questionnaires have been sent to me about the last time they were in contact with the NHS, when the last encounter was and the background. Is that sort of audit happening routinely in all boroughs or not?

Dr Tamara Djuretic (Public Health Consultant, London Borough of Haringey): Potentially what you are referring to is the suicide audit within the hospital. All deaths due to suicide in acute hospitals are subject to individual audit and there are detailed audits for individual cases in the hospital. The number of suicides taking place in a hospital or related to a hospital is going down and the number of suicides in the community is

going down. There is not an equivalent process for those deaths happening in the community by suicide in terms of that audit.

What I was referring to earlier by a suicide audit and what we mean by that is not necessarily in that sense individually straight after the incident happens, but what we do is we go back to the coroner's office and then pull out individual case notes retrospectively for a particular number of years and look through that. It is retrospective and so we rely on what has already been recorded. When we look at all the suicide audit data, those that come from hospitals, because that tool is established, are probably the most detailed.

Dr Onkar Sahota AM (Chair): Not every single case is being followed up but there is that detailed inquiry afterwards?

Dr Tamara Djuretic (Public Health Consultant, London Borough of Haringey): Yes.

Dr Onkar Sahota AM (Chair): That may be one of the recommendations that we may want to make.

Shaun Bailey AM (Deputy Chair): I just want to circle back to the coroner and the police in particular because the Mayor, in the context of London, has great sway over the police. I was very interested that you said that the police provide information on suicides. How do they know that? They are not in a position to decide if someone has committed suicide or not.

Jane Powell (Chair, Campaign Against Living Miserably): They can do. There are trials in the rest of the UK - which I am sure you can talk about - where they are the people who are informing the family. It is a D1 form, or it is in Northern Ireland. They will fill in the cause of death. They have the opportunity there to fill in other details around ethnicity, age, work status and marriage status and also to make contact with the family and to make sure. That is a route where they can deliver local information about help that might be available.

They cannot take the coroner's role and say, "This is suicide". As David [Mosse] indicated, coroners have a range of options in terms of how they record a death and there is a need for a criminal basis of evidence for that death. However, a number of those deaths are clearly by the person's own hand and are not necessarily recorded as suicides.

The data that we have on suicides has big gaps. The clear evidence is that you will take your life by the easiest form and the most accessible form. Hanging is huge. There is very little data on, say, road deaths, but over the last ten years more men I have spoken to would say that they have thought about or attempted to kill themselves in a car driving into a fixed object than have talked about hanging, say. The data needs to be viewed with caution as a potential underestimate. Something that CALM has been concerned about for some time is that the data is -- Gary Speed's [Welsh professional footballer] suicide was not considered to be a suicide.

Shaun Bailey AM (Deputy Chair): One of the recommendations we could be making to the Mayor is to look at how this pilot is going in Northern Ireland and maybe adopt some of the tactics ourselves. That is something the Mayor has great sway over.

Just to move on to the coroner, it strikes me that coroners are quite an independent bunch and are a law unto themselves, maybe rightly so. Is there any way of asking or compelling them to change the way in which they collate their facts around suicide or is it the case that we would have to go to Parliament on that? We are looking for things that the Mayor can actually influence.

Professor David Mosse (Chair, Haringey Suicide Prevention Group): There is now a Chief Coroner. The Chief Coroner's role, as I understand it, is to ensure or encourage consistency in practice across jurisdictions and so that would be an obvious point of contact.

Just to pick up on the point that was just made, in working with the police and in the police working more closely with the coroners for information flow purposes, in such cases we are talking about suspected suicides. Given that this is also about trying to make available support for families, it is very important that this whole question is handled extremely carefully and the language used is chosen with care. In these experiments of working with coroners and the police and getting real-time information available to support families, it is something that attention is paid to.

There is probably much to be gained from looking at best practice. I am aware, for example, of a coroner in Cambridgeshire and Peterborough who was able, because of regular contact with the local suicide prevention group, to make available information so that they had early notice of a cluster of suicides among migrant workers in the Fens. They were able, with Public Health support, to get information and support out to families long before these would have been determined to be suicides through an inquest process, to begin the support and the prevention and post-vention work early and to be aware of a cluster of suicides in a way that simply would not have been possible had one had to wait until after the inquests.

Shaun Bailey AM (Deputy Chair): Can I ask a slightly naïve question? Among coroners, is there a protocol to determine if something is a suicide and when and how to report that or is that not the case?

Imagine I was a coroner. Is there a protocol that I follow to determine if something is a suicide and does that protocol then tell me who to report it to and what to report? Does that exist?

Professor David Mosse (Chair, Haringey Suicide Prevention Group): No, the practice is in terms of criminal standards of evidence --

Shaun Bailey AM (Deputy Chair): There is no routine way --

Professor David Mosse (Chair, Haringey Suicide Prevention Group): -- that beyond reasonable doubt that a person had taken their own life and had intended to do so.

Shaun Bailey AM (Deputy Chair): Once that decision is made, does a coroner have a set of people that that information is provided to routinely?

Dr Paul Plant (Deputy Director, Public Health England (London)): That is how we get our national statistics. It goes up to the Office of National Statistics in this process of reporting. We are talking about a number of things here and we need to be clear what the purpose is. Changing the national system to be accurate and consistent would take a national system and it would have to go through the Chief Coroner and through to the Office of National Statistics.

There is this potential under-reporting issue, which I said in my opening statement, which is that the suicide rate itself is important but a broader understanding of a number of groups who are in distress - be it men, etc - is where we should be focusing our effort and there are other statistics that will give you those clusters.

What the pilot is doing - which sounds great and I do not know the detail - is saying that there is some real-time data and, if we move collectively, we can spot clusters. That is the third bit of this.

The fourth bit we have been talking about is that some of our public services, who are coming into contact very early with a death in very distressing circumstances, need to be able to talk across agencies and handle that sensitively with families. This is a crucial few hours, days and weeks. If it is not handled sensitively by people who are skilled at doing it, they will just add to the damage within the family.

My understanding of what families want is to deepen their understanding of the question why. That is at the heart. They want to know why. That is quite a complex thing, which a routine statistic will not get you to. It is about circumstances, about history, about who has seen them in the 24 hours before. It is really crucial.

In any strategy, you need to tease out what the data is trying to do. The national data gives us enough to understand the target groups we are looking at. We do not have enough real-time data to spot early trends and that is worth pursuing.

Then there is this whole bit that any local strategy should be doing: equipping people to handle this situation really carefully. Labelling something as "suicide" when it is unproven is not helpful to a family. It might be when you have been through a process, but not in the first few hours. I personally would not want a police officer turning up and coming --

Jane Powell (Chair, Campaign Against Living Miserably): No, as David [Mosse] said, it is a suspected suicide.

Can I come on to that, though, very briefly? On the clusters, the immediate family or the ex-girlfriend are clearly at risk, but what we have found elsewhere from If U Care Share Foundation is that quite often there will be further suicides within that community of people. The statistics are not going to show you that, but for the friends and the girlfriends of the friends and the person who served them, sometimes the impact is almost impossible to gauge unless we push.

I was in a cab and the driver told me about the suicide of his neighbour. He had never spoken to the woman. Everybody knew that she had just divorced. She was crying in the car and the car would not start. He thought about offering help but decided against it because the community would gossip. She then drove off a cliff. He had no contact with her.

The impact can be quite far-reaching. We see, particularly on the helpline, friends of the person who took their life, teachers who knew that person, girlfriends of friends and the classmates. The impact can be quite far-reaching, which is why that local Londonderry model is so important.

On the recording, there are many families who have been frustrated by a death that was not deemed to be suicide when the families who feel that it very much was and who are quite distressed that it was not recorded as such.

Shaun Bailey AM (Deputy Chair): Does that work the other way as well? Is there a group of families --

Jane Powell (Chair, Campaign Against Living Miserably): It works both ways. I have listened to coroners explain that, "He might have left a note, he might have jumped off a bridge into a river, he might have intended to kill himself and he did indeed kill himself, but halfway through that attempt he tried to swim to the bank. Therefore, he did not intend to kill himself but he drowned and so that was not a suicide, clearly".

Shaun Bailey AM (Deputy Chair): Just help me understand. Could another coroner quite legally interpret that a different way?

Jane Powell (Chair, Campaign Against Living Miserably): Yes, and they have. Some deaths have been deemed not suicides because the people were clearly drunk at the time. He might have left a very long note and it might have been very clear from everything that he had done that he intended to take his life, but given that he was very distressed and drunk and perhaps on drugs, it was not a suicide. I agree with David [Mosse] that it needs to go to the coroner, but it is frustrating to see the flexibility within which coroners will record a suicide.

Shaun Bailey AM (Deputy Chair): Again, would it be helpful if there was - for want of a better word - a definition or a way that suicides legally presented themselves? The under-reporting could be really serious. If we are not all looking at the same thing, we are bound to get under-reporting, surely.

Professor David Mosse (Chair, Haringey Suicide Prevention Group): I suspect - and I think most people who do know and work in this field - that there is under-reporting because of the overlap with accidents and things that Jane [Powell] has mentioned.

However, the issue we are looking at is that deaths by suicide and deaths that have suicide verdicts are the very tip of an iceberg and the iceberg has many different levels. It becomes increasingly large numbers when you look at the number of people who attempt suicide, who are themselves the most at risk of killing themselves, and when you look at those who have made plans or have had thoughts of suicide and so suicidality. When you look at the deaths by suicide, you are looking at the very tip.

Apart from this question of whether there are more deaths that should be understood as suicides, if we look at the problem of suicide more broadly, then we have to recognise it as a problem that is far wider and more pervasive than the statistics on deaths show. That is perhaps another way of looking at the issue.

Shaun Bailey AM (Deputy Chair): Thank you. Let us just segue into our next tabled question here. What we are looking to get an idea of is how suicide prevention activity is taken across London. Who does it? Is there any co-ordination of it across London or are you in your isolated borough doing it your own way, having no need to convene with anybody else about how you are going to prevent suicide?

Dr Paul Plant (Deputy Director, Public Health England (London)): We are currently surveying the boroughs. We have not finished doing it yet, but 18 do have comprehensive strategies and the majority of the rest are in various stages of developing strategies in line with the national strategy. From Public Health England and our colleagues and the Association of Directors of Public Health, there is this push to achieve the ambition that every borough should be doing something.

Some of the boroughs are embedding their suicide work in broader mental health strategies. You might not see it labelled as a "Suicide Prevention Strategy" because they have a broader one. We are currently surveying them to see the extent to which we are doing it.

With Tamara [Djuretic] and her colleagues, there are support mechanisms across the public health system to make sure people learn from each other, learn from good practice and are able to work together. As Tamara has already mentioned, there is a workshop coming up in December 2016. Then there is a big system one in March 2017 and we have invited the Secretary of State [for Health, Rt. Hon Jeremy Hunt MP] and other people to give this another push and to say, "This is a major issue for London. How can we help? How can we learn across the piece?"

From a position where not many boroughs were doing that, we have made quite a lot of progress. Public health being in the boroughs now has helped that push to say, "Public health aspects of mental health are really important", and this is one particular aspect of that. I think Tamara probably has a more detailed understanding of that.

Dr Tamara Djuretic (Public Health Consultant, London Borough of Haringey): Thanks, Paul. Yes, I was just going to add to that. There was an All-Party Parliamentary Group [on Suicide and Self-Harm Prevention] survey in 2015[1] and only 11 out of 33 boroughs had suicide prevention plans. That is now increasing: 18 have established plans and another 11 are developing their plans.

I just want to float something from public health. Every single life taken by suicide completion is a disaster for the person who is not there but it is also one for the family and everyone around that person. However, the numbers are extremely small compared to numbers of deaths due to other causes such as cardiovascular disease or cancer.

In terms of public health and extremely shrinking resources, at the local level they need to make extremely difficult decisions as to how to channel the resources and, therefore, we see a variation in their approaches. Some boroughs have chosen to go for an individual suicide prevention plan and others have integrated plans. No approach is better than another and we have not really systematically evaluated to see, but the national recommendation is to have a suicide prevention plan. The reason is because that would then attract further resources and it would also show that there is a strategic buy-in to suicide prevention at a local level.

In terms of, I think, the five year forward view , the NHS on mental health is asking all localities to have suicide prevention plans by 2017 and so that will inevitably help, but --

Shaun Bailey AM (Deputy Chair): Do you feel that we are on target to hit that in London?

Dr Tamara Djuretic (Public Health Consultant, London Borough of Haringey): Most local authorities are now moving towards that. Having a plan is one thing and then implementing a plan is a different thing. How one implements the plan with limited resources is the question.

In terms of looking at the different plans across London, what are the components of a good plan? The East of England region also has evaluated the number of plans against the reduction in suicide. The main features are a strategic ambition articulated across the whole health and wellbeing board, usually, and acknowledged by the local health and wellbeing board, dedicated resources towards suicide prevention plans, a multiagency whole-system approach and then real partnerships between community groups.

The major focus in all localities is about data-sharing because we know that you cannot really improve suicide prevention planning if you do not know the local data. It is not just about the coroners. Coroners are crucial and important but, going back to David's [Mosse] point, attempted suicide is something that we discussed at the roundtable, which we will probably come on to. Mostly police are called to attend these attempted suicides with a 111 call and it is not being recorded and so there is no way to then go back to either primary care or whoever was in contact with that particular person to try to prevent further suicide attempts and, unfortunately, potential completion of suicide. That is what local groups want to really focus on. It is not necessarily an easy one because you do need the national sign-up to it and my understanding is that Public Health England is looking into real-time reporting anyway with data-sharing across the agencies.

[1] Report available from: http://www.samaritans.org/sites/default/files/kcfinder/files/APPG-SUICIDE-REPORT.pdf

Then there is something about stigma and anti-stigma campaigns, which are not necessarily talking about suicide but are talking about mental ill-health and access to services. We know that one of the major risks for suicide is undiagnosed or undetected depression and another one is substance misuse. We have evidence to show that one of the big risk factors for suicide is substance misuse. That is also part of suicide prevention planning. It is much wider than just focusing on reducing means.

Jane Powell (Chair, Campaign Against Living Miserably): We are commissioned in the tri-borough area to reach out to men within London. We have been for the last three years and we are expecting that commissioning funding stream to end next year [2017]. As I said, we take about 2,000 calls from men from London a month. We also have been doing various campaigns reaching out to our audience, working with Lynx on the "Bigger Issues" campaign and also promoting and pushing out the helpline number and webchat. We see, particularly for young men, webchat as hugely successful.

The concern that we have sometimes around some of the mental health campaigns is that they are not brilliant at reducing stigma. Most suicides across the UK are taken by men and are taken by men who are not accessing any service at the time. They do not really see themselves as having a mental health problem. Somebody walked into the office the other day desperate for some information and saying he was going through a divorce; what do we have? The reasons people take their lives and the reasons men take their lives are things around breakups, bereavements, shame, work going badly wrong, family going badly wrong as well as health problems or exam stress. They do not think or see themselves as having a mental health problem. They see themselves as having a really horrid time, being unable to cope and feeling that they are failing as a man and, therefore, the only way out for them is to stop burdening their family and to leave. In terms of how any campaigning is done, it is important to think about the bulk of the people who are likely to take their lives, who are men.

We are not going to be able to sustain a dedicated helpline for men in London much further if the tri-borough funding runs out. We have also been supported by City Bridge [Trust] but, again, that grant has now ceased despite being renewed for a further two years, simply because they do not do repeat grants. We have been taken about 2,000 calls and webchats from men in London a month.

Shaun Bailey AM (Deputy Chair): Thank you.

Jane Powell (Chair, Campaign Against Living Miserably): To add to that, we know that nationally we prevent - or believe we prevent - about two suicides a day.

Professor David Mosse (Chair, Haringey Suicide Prevention Group): Can I just address this question of the value and importance of a distinctive and separate attention to suicide prevention? Suicide is a problem that in a sense is different from a range of other public health concerns precisely for the point that Jane [Powell] mentioned: the vast majority of people who end their own lives have not been in contact with the health service. It is very much something that has to be taken to the community. Suicide prevention is everybody's responsibility. It involves bringing together the widest conceivable range of agencies, actors and institutions, specialist and non-specialist, across the sectors and the raising of public awareness. It is an intervention that requires bringing together unlikely combinations of people.

We have a community-led Suicide Prevention Group in Haringey that has done this and brought together people involved in housing, Jobcentres, the charities, the public sector and statutory and non-statutory bodies. From the nature of those discussions, it is clear just how unique these conversations are and how particular the kind of problem that is being addressed in order to address suicide prevention is.

The other thing is allocation of resources. The financial case for suicide prevention is very strong indeed. It is estimated that a suicide costs £1.7 million and that is at prices of several years ago, 2009, in terms of the care and the lost productivity. It is almost impossible. How can one put a financial figure on what is a human tragedy that ripples out into many people's lives? You can through the disciplines of health economics and others. That means that the 31 suicides that there were in Haringey in 2014 cost £51.7 million. It means that a 10% reduction in suicides will save £5 million.

When we look at the finances around the allocation of resources and we look at the costs, even in narrow financial terms as well as in wider human terms, the case for a focused attention on suicide prevention is overwhelming.

Dr Onkar Sahota AM (Chair): Professor David, do you think that the spending on this preventative work has been going up over the years or has it been going down?

Professor David Mosse (Chair, Haringey Suicide Prevention Group): I am not in a position to answer that. Maybe others can.

Jane Powell (Chair, Campaign Against Living Miserably): Ours is, as I have said, about to end fairly soon. Talking with the Commissioners across the UK, they are really struggling.

Professor David Mosse (Chair, Haringey Suicide Prevention Group): What I would like to say is that a lot of the preventative work that is available through the community and charity sectors has been very severely hit by cuts to funding. That has knock-on in terms of the sorts of institutions and organisations that could, would and should be involved.

Dr Onkar Sahota AM (Chair): The second point I just wanted to pick up - and correct me if I am wrong - is that you think it is very important to have a specific strategy on suicide prevention rather than it being part of a mental health project.

Professor David Mosse (Chair, Haringey Suicide Prevention Group): That is my view.

Dr Onkar Sahota AM (Chair): Yes. I wanted to pick this up with you, Dr Plant. It was September 2012 that the Government published the cross-department strategy for suicide and improving support in England [*Preventing Suicide in England: a cross government outcomes strategy to save lives* [2]], which said that there should be a plan right across each borough. The All-Party Parliamentary Group survey on Suicide and Self-Harm Prevention stated that there was a whole variation about implementation across the country and perhaps on the steps and what should be done to implement this.

Here we are now hearing that 18 boroughs out of the 32 have a strategy and 14 do not. Who is driving this in London? Who is monitoring what the boroughs are doing? Who is holding the boroughs accountable for what is happening?

Dr Paul Plant (Deputy Director, Public Health England (London)): Just on the figures, there are 11 further ones that are in the process of getting to the same point as the 18 and so --

Dr Onkar Sahota AM (Chair): We are still four years behind these.

[2]Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/430720/Preventing-Suicide-.pdf

Dr Paul Plant (Deputy Director, Public Health England (London)): -- we have had a significant increase in activity across the boroughs in the last two years to go from that low-level position to having a plan.

Dr Onkar Sahota AM (Chair): That is easy when you have a very low-level rise. It is easier, but how are you monitoring what is happening across the boroughs?

Dr Paul Plant (Deputy Director, Public Health England (London)): That is what I am saying. We are currently surveying them to find out precisely what they mean by the Plan and where they are getting to. We have an ambition by April 2017 to get them all there, but that is really unlikely given what we know about local authority finances. Public Health went to local government without an oversight that says that some people like Public Health England or the Department of Health can say, "Thou must", in all of these statutory areas or else we would have to have them for childhood obesity, etc. Our role --

Dr Onkar Sahota AM (Chair): There is a lack of strategic leadership in London?

Dr Paul Plant (Deputy Director, Public Health England (London)): No. I am saying that we have gripped this to get this position from going from a very low level, working with the Directors of Public Health, and so we are doing everything we can to argue that this is a good thing, to provide analytical resources and to provide the ability to learn. That is how the public health system works now. There is not an overview body that says, "Thou shalt", on anything. It is about that --

Dr Onkar Sahota AM (Chair): I interpret that as lack of leadership in London and fragmentation of services in London. That is how I interpret that.

Let me pick up something else. You said that some boroughs were happy - or you were happy - that they were making suicide part of the mental health strategy and here we have Professor David [Mosse] telling me that it is much better having a separate programme for suicide prevention. Why is Public Health England (London) happy for boroughs to make suicide prevention part of mental health rather than having a specific strategy for it?

Dr Paul Plant (Deputy Director, Public Health England (London)): I am very happy to be shown evidence that one is better than the other. As Tamara [Djuretic] says, we are concentrating on what the right things to do are rather than what the label is or what we call it. Therefore, that is what we are looking at: how many are multi-sexual, how many are targeting high-risk groups...

Dr Onkar Sahota AM (Chair): You think there is a lack of evidence in that field?

Dr Paul Plant (Deputy Director, Public Health England (London)): I have not seen any evidence that says that a separate plan reduces rates quicker or more effectively than an integrated plan. What is true is that there are some key actions you can take for high-risk groups, however you do it, under that iceberg model that have an impact. That is what we know.

Dr Onkar Sahota AM (Chair): If there is any evidence around, if anyone is listening, let us have it, please.

Dr Tamara Djuretic (Public Health Consultant, London Borough of Haringey): It is also about being realistic. We know that the best or, let us say, the optimum potentially would be to have a suicide prevention plan, but realistically at the local level one would then need to have a strategy for violence against women and girls and then one would have another strategy for reducing depression and so on. At the local level, with restricted resources, we are trying to integrate it as much as possible and then focus on specific high-risk

groups. One might see suicide as an unfortunate outcome of the system before and the whole pathway in terms of mental ill-health failing, and so I would advocate that any suicide prevention plan, if it is integrated well within the mental health overall strategy and prevention, should really be successful.

The All-Party Parliamentary review asked just for a suicide prevention plan and did not really ask questions about whether there is a suicide prevention focus within the strategies. It is similar in this survey. We really need to be cautious in terms of what the minimum standard is, what the optimum standard is and what the best ideal case scenario is, if there are enough resources at the local level. It has to be a health and wellbeing board decision as to how to allocate resources.

Dr Onkar Sahota AM (Chair): Thank you.

Unmesh Desai AM: Do you think a pan-London approach to suicide prevention is needed and, if so, what are the key areas such a response would need to address? It is really to all of you.

Amanda Coyle (Assistant Director, Health and Communities, Greater London Authority): You will be aware that the Mayor has a specific manifesto commitment to co-ordinate efforts to reduce suicide in London. Indeed, City Hall hosted a suicide prevention and reduction roundtable in August [2016] to inform our view on that.

You will probably also be aware that the Mayor is very committed to developing a citywide strategy for mental health to ensure positive mental health is a priority for all citizens. Within that, we do see some key elements of that strategy, namely in and around stigma and conversations around mental health to make it a more day-to-day conversation and, in some senses, support those people who do not typically access mental health services, as you have rightly mentioned.

We do see our role as building on existing work. We think that it must have the constituent parts of bringing together multiple city agencies and providers if it is to be successful. We are early in our conversation on that to understand what value a pan-London strategy could bring in terms of bringing the multiple people who are working in this area together.

There has been a lot of discussion around prevention and, clearly, it is one of the key priorities of this Mayor. We see programmes like Healthy London Schools as being a key to that. It has a whole mental health element to it in terms of teaching our children to be able to understand how to look after their mental health and how to be able to express that. We have done quite a few workshops with our peer outreach group. Indeed, Onkar [Sahota AM, Chair], I think you attended one a couple of months ago. That is really a key to informing what a pan-London strategy would look like. Also, in the area of prevention, we are looking at the school curriculum and the London Curriculum on personal, social and health education, which covers really important topics like mental health, resilience and what children need to do to be able to look after themselves.

To answer your question, it would be a collaborative strategy to be able to look at suicide prevention working with the boroughs and Public Health England and, clearly, the third sector would have very significant input - and academics - to make sure that it adds value.

Dr Paul Plant (Deputy Director, Public Health England (London)): Can I just pick up one thing that predates the current Mayor? We are working with the boroughs and all of the London Clinical Commissioning Groups to put in place a digital mental health and wellbeing service for Londoners.

When we did lots of work on this - and it relates to Jane's [Powell] point - most people in mental distress do not have the language or do not have a diagnosis to say, "I have X", and they do not seek help in traditional ways. They do not start going on NHS Choices saying, "What can I do for my depression?" They just do not do that.

It is only a partial solution because we need the local support, we need the Mayor's leadership, etc, but what we have been looking at it is where these high-risk groups are digitally. Are they talking about these issues on the mumsnet? Are they talking about them when they log into their football supporters website? Are they talking in different places? What we are trying to do is to get the high-risk groups and find out where they are digitally and link them to what we know is available resource and help.

I understand the pressure the sector is under, but there are lots of really good access points that not everybody will know about or will not think are for them. We have this strategy. A really concrete example would be: it is 1.00am, cannot sleep, mind racing about X, but somebody will be online somewhere. Our digital colleagues can find them and say, "What you might want to think about is going here or have you thought about the local psychological therapies and the access point is here? You can take this online assessment and it will give you a way in or you might want to talk to someone like Jane [Powell] or you might want to go to Mind [mental health charity]". What we are trying to do is to link 6.5 million Londoners into a digital space that gets them more easily to existing places. It will get them to evidenced-based places, which are safer than just Googling. It will get them into peer-to-peer support groups. It will put them into the right bit of the existing services.

We know that about 75% of Londoners with some form of mild mental health problems get no support. It is as stark as that. We cannot just lift them all into primary care; we cannot just lift them all into accident and emergency departments (A&Es) or the mental health trusts. We are going to have to think of something different for them. It is that iceberg element. It is not the conversations Jane [Powell] will be having in a really detailed way, but we might be able to link more people. There is an issue of resourcing and other things. It is not a panacea that is going to solve everything, but at least it is a new attempt at a pan-London level to support Londoners and a distressed system.

Shaun Bailey AM (Deputy Chair): Sorry, just before you start, you are suggesting that what is being built now is a portal to help people find existing services?

Dr Paul Plant (Deputy Director, Public Health England (London)): Yes.

Shaun Bailey AM (Deputy Chair): Would it not have been better to spend that money to get those existing services higher up the Google --

Dr Paul Plant (Deputy Director, Public Health England (London)): No, it is really cheap –

Shaun Bailey AM (Deputy Chair): I work in a community setting and have always done. Nobody I know who is in trouble contacts the Government.

Dr Paul Plant (Deputy Director, Public Health England (London)): It is not the Government.

Shaun Bailey AM (Deputy Chair): Yes, but that is how it will be perceived. That is what I am trying to get to. Am I at any point contacting, through your service, something that looks official? I will Google. People will absolutely Google. I wonder if, for those services that you are trying to promote, it would just be better if you pushed them up a Google search because that is one less step. I am always concerned with anything that

is internet-based about the number of steps. It just strikes me that it would be powerful if you could reduce the steps and not add one.

Dr Paul Plant (Deputy Director, Public Health England (London)): Our understanding when we did the discovery work and interviewed real Londoners is that there is a whole set of people who would do that and that is great. This is not just a single solution. There is a set of people who do not have that language and have not got to that space but there are things available for them to help. That is the bit we are talking about. I am not saying that what you would like to see happen is a bad idea. I am just saying that there is another element. This is very low cost to do on a pan-London basis. It is simply adding. The question was: what more could we do at a pan-London level? I am not saying this is a replacement for everything; I am just saying it is an addition to use some existing tools to help more people on that --

Shaun Bailey AM (Deputy Chair): I understand and I agree, but it looks like one extra step that could have been reduced.

Dr Onkar Sahota AM (Chair): Thank you.

Jane Powell (Chair, Campaign Against Living Miserably): At the moment, we have information about agencies within the tri-borough area. If we have someone ringing or contacting us through webchat, we can refer locally to those agencies within the tri-borough area. We do not have information about all the agencies in London because we are not commissioned across all the agencies in London but, if we were, then we could directly signpost.

There is a real need to have a pan-London view because quite often people will ring up and they work in one part of London and live in another part of London. Where they have a crisis can be anywhere within London or even outside London. If we are going to connect people up with particular support - if they need to go to Alcoholics Anonymous or Narcotics Anonymous or if they are homeless - it is important that we can connect up directly through that.

There are two points I would like to make. One is that every time we expand our capacity, the calls grow. We do not promote the phone number; we promote the website and that goes out in magazines and on sharing materials and advertising across London. Effectively, the tri-borough has been subsidising the other London boroughs by enabling us to take their calls, but we are able to support and signpost back to only agencies within the tri-borough area or agencies nationally.

My big question is: a suicide prevention plan needs to be there and so what happens when we have a caller who clearly needs counselling, we have him to the point where he will access that, his response is, "I have accessed it and I am on a six- to nine-month waiting list", and he comes back and is told, "Actually, it is going to be 12 months"? The problem we are finding is that the support is not there within the statutory services. The capacity is not there within the statutory services. At the end of the day, we can take a call. It is anonymous; it is confidential. We cannot provide counselling. We definitely prevent suicide and we will give the caller as much time as they need to talk through and they can call back as many times as they want, but there are times - and they break your heart - when there is nothing out there for them because they cannot access the support and the support is not there when they need it.

Dr Onkar Sahota AM (Chair): Jane, I share those concerns. As a practising doctor, I see this day in and day out in my practice. This is a great problem we face.

Professor David Mosse (Chair, Haringey Suicide Prevention Group): That is a really important point. I would just like to make a few related points about services and what could be done in London.

One thing is the crisis care pathway and what to do if someone you know or even you, or somebody else is in crisis. It is very unclear what the points of contact are. Even internal to the crisis response and home treatment teams there is a lack of clarity about what the process is. What is required is an effort to communicate a very clear message and idea about what services are available for people who are in crisis and particularly people who are in suicidal crisis and simply information about where the places are to go. Public knowledge about this is extremely limited and I get people contacting me all the time saying, "I know somebody who is in desperate crisis. What do I do?" You have to think: what do you do? There is not a clear answer. There is not a clear pathway. There are various phone numbers and there are administrative referrals to get people into a crisis response and home treatment team or whatever. The connections and the pathway and clarity and communicating that is important.

The other thing is linked to what Jane [Powell] has just said about the problem with a lack of services. That is down to pressure on the health service but also the real cutting back of funding available for some of the mental health charities and voluntary services. I am a trustee of Mind in Haringey and it is very difficult to keep those counselling services going. They are often the services to which people are referred from statutory services but they are just surviving and so the second line available in the charity sector is also under threat.

Another need that comes up repeatedly is that people in crisis want face-to-face contact. That is the hardest thing to get access to. They often need it quickly. The way that A&Es handle people in a suicidal crisis is problematic and needs to be examined. What kind of environment is there for somebody in a suicidal crisis? How appropriate is that? Are they simply held, quickly assessed and then sent out? Is that an environment that is appropriate?

There have been recent initiatives to extend opportunities for face-to-face conversations for people who are suicidal. The Listening Place is an initiative that has just started up near Vauxhall. It takes referrals and also some self-referrals. London has the Maytree. The Maytree is a unique instance. It is a sanctuary for the suicidal. It is a place that people can go to and stay for two or three nights. It is the only place of its kind in the country. There ought to be Maytree houses in every borough because they provide such an important service. It is a non-medical environment in which people can openly talk about their thoughts of dying and get through what is perhaps a momentary crisis, what is perhaps a moment that will pass, to get to the point where they can interrupt that potentially lethal trajectory towards suicide. Those are things that are happening on a small scale but they are good examples of practices that need to be expanded and made more widely available.

Dr Tamara Djuretic (Public Health Consultant, London Borough of Haringey): For me, thinking about what could be done at the London level, we welcome the London Health Board's focus on suicide prevention and things are emerging. However - going back to your point - there is something about strategic leadership and potentially political leadership in London to ensure that suicide prevention is potentially a priority.

Suicide prevention is not just a health response. There is a non-health response as well. It is thinking about it across different departments in City Hall and across London as well such as the police, Transport for London (TfL) and communities. It is thinking about a whole-system approach to suicide prevention at the London level that would then filter into the boroughs' plans.

Lastly, something we have not talked about is that some statistics do tell us that six to eight weeks before suicide people were in contact with services. There is something about systematic training across London for frontline staff in terms of health services, not necessarily just health services but also libraries and businesses,

to raise awareness. It is talking about mental health but also talking about potential signs of suicidal ideas. It is if someone was, for example, coming into a library in distress, how the library staff would be equipped to potentially help those people there and then.

Shaun Bailey AM (Deputy Chair): How deeply would someone have to be trained to be of any real use? Would you have to be a more qualified counsellor or would you be able to teach laypeople?

Dr Tamara Djuretic (Public Health Consultant, London Borough of Haringey): There are different levels, certainly, depending where we are. What I am talking about is more at the awareness raising level. There is some mental health first aid training. There are two-day courses for overall mental health. Maybe it is thinking about something similar for suicide prevention or linking with a potential London Health Board discussion about mental health at the London level overall. We have never had a discussion. We have talked about symptoms of cancer: bleeding, coughs. We never talk about mental health openly and there is an opportunity to do that.

Professor David Mosse (Chair, Haringey Suicide Prevention Group): The idea is that suicide is everybody's responsibility and the key message is that it is safe to talk about suicide. The only way that somebody can be protected, if that is possible, is by a conversation that brings up the subject of suicide. It is safe to ask somebody, in an appropriate way, "You are going through a really difficult time. That must be incredibly hard. Does this make you feel like ending your life?" That is an extremely difficult conversation to have.

There are all sorts of very powerful emotional blocks to raising the issue of suicide. People have the mistaken idea that talking about suicide puts the idea into people's heads and therefore is a dangerous thing. However, the evidence is that it is the reverse. What is important is having the skills - even very basic skills - to talk openly and allow somebody to talk about their suicidal thoughts.

A leaflet was produced on the basis of research at Exeter University that has now been reproduced by Public Health in Haringey. It is a simple pamphlet that says it is safe to talk about suicide. It is aimed at general practitioners (GPs) and other centres. It is a public health message that the people who can protect and make an environment safer from suicide are friends, workmates, neighbours, people who will act on a hunch. One of the messages for family members is to trust your intuition. If you are concerned, then talk; ask. That is a very important message to get out to the wider community.

Unmesh Desai AM: One more question, Chair. Ms Coyle touched on this to some extent, but what role does the Mayor of London have in all this?

Jane Powell (Chair, Campaign Against Living Miserably): We have been polling Londoners for the last four or five years, "What do you think is the single biggest killer of young men in London?" Awareness has risen year on year. It started at about 10% in 2012 and it is now at around 38%. One of the things families say is, "It never occurred to me that he would take his life. If I knew, then I would have done something". If we are going to allow people the opportunity to intervene, then we need to give them that knowledge and to allow them to then find out the information and find out what kind of conversations they can have. Unless they know, they are not going to do it. My typical young suicide would be male, loved by all, talented, sensitive, probably quite ambitious, drinking too much, fun-loving and taking a lot of risks. That is not how people see a young male suicide: as friends with everybody and with a girlfriend.

The leadership that can be set is saying that you take this seriously, that it is the single biggest killer of men under 45 in London, and to allow families, to allow friends and to allow best mates to know that if they are

worried, this is something they should be worried about. What do I say to a mum who says, "I was worried about his drugs. I was worried about his driving. I was worried about violence. It never crossed my mind he would kill himself, but I knew he was depressed"? We need to make sure that conversation never happens simply by saying you are taking this seriously, you are going to invest in this. If nothing else, that would allow Londoners the possibility to prevent more suicides.

Amanda Coyle (Assistant Director, Health and Communities, Greater London Authority): I wanted to comment on what Tamara [Djuretic] said. Clearly, the Mayor, who chairs the London Health Board, has a clear leadership role to be able to galvanise partners around a pan-London mental health programme. Embedded in that is a suicide strategy. As you rightly pointed out, a large proportion of it is the conversation that has to happen with Londoners, within communities, across groups and across generations so that we as Londoners can take and step up to a citizenship role that encourages us, gives us permission and gives us the skills to be able to have difficult conversations and also to be able to support both our young people - and indeed men - if they are experiencing these types of symptoms. It is only through a combined community effort where we all share the responsibility and play our role as citizens of London that we will be able to crack this and reduce the suicide rate.

Dr Onkar Sahota AM (Chair): Amanda, the second part, of course, is that if we give people permission to have this conversation, then how does the system react to that conversation when we hear the answer, "I want to commit suicide for X, Y reasons"? What service is available to us? How do we respond? Who is picking up that second part of the conversation? We have given them permission to talk. The answer comes back, "I am suicidal. I need help". How does our system respond then?

Jane Powell (Chair, Campaign Against Living Miserably): Not all suicides necessarily need medical intervention.

Dr Onkar Sahota AM (Chair): It may be psychological.

Jane Powell (Chair, Campaign Against Living Miserably): There are loads of guys where we take the calls and they just want to be able to talk to somebody and feel normal and talk about what it is that they are going through. They are not necessarily having a mental health crisis. There are callers who have just seen their house burn down. Is that a mental health crisis or do they actually have a real issue facing them? There is a whole wodge of people who definitely and absolutely need to talk to somebody now and need that medical intervention but that is not all of them.

It is about making sure that we have connected-up services so that if somebody is going through a divorce, is homeless or has huge work problems, they can find some kind of assistance is not necessarily all about, "This person needs mental health treatment". The flaw is that when we signpost it, the help is not there. When we know we have somebody who needs that help now, the help is not there. Giving someone permission to be able to talk about what it is they are going through and to be able to give them permission to talk about feeling suicidal is huge and can make all the difference in the world. That anyone can do.

Professor David Mosse (Chair, Haringey Suicide Prevention Group): To follow up on that, when intense feelings of suicidality are transitory, they may recur but in that moment of intense feeling and being in the process of enacting a suicide attempt, what is necessary is to interrupt that process. This involves a set of issues that are separate from the issues of how to enable someone to engage in the longer term with services and get support. Of course, that is why the thing for which there is greatest evidence in suicide prevention is prevention of access to means, fences on bridges and buildings and so on. They will interrupt an intense but perhaps transitory moment. It is known from many of those who have survived their own suicide attempts and

talked about their experiences how incredibly grateful they are to have a second chance. It is the stranger on the bridge situation. It is important to think about all the possible ways in which the closed-off pathway to suicide can be interrupted.

A separate question is how to get people into support. This is where greater public awareness about the crisis support services is important. However, it is probably necessary to separate those things out.

Unmesh Desai AM: From the answers that have been given to us, the Mayor can play a role in playing public awareness. Really what I was hoping for, Chair, were more specific examples as to what the Mayor's office can do to raise awareness.

Professor David Mosse (Chair, Haringey Suicide Prevention Group): On the prevention of means, it took a ten-year campaign, I believe, to get agreement that there would be protective fencing put on the Archway Bridge. It should not take a ten-year campaign to do what was an obvious thing to do given the number of suicides that took place. Agreement has been reached. TfL has designs in place. It has taken an enormous amount of time and the fencing is still not up.

There are many areas where co-ordination between different agencies would be of benefit to look at all the areas within the city where there are relatively straightforward measures that would prevent access to the means of suicide through buildings, bridges, roads and so on. For example, at railway stations, a lot of work has been done by the British Transport Police and Network Rail looking at the railways. It is joining up some of this thinking and enabling permission to get through so that the work can be done.

Shaun Bailey AM (Deputy Chair): It rolls on from the questions that have been asked. What can be learnt from the approaches taken by other regions, other cities and other parts of the world? Is there any best practice that we could enact in London that the Mayor needs to be made aware of that would help this issue move on? For instance, the police trial is particularly interesting to me because the Mayor runs the police and so he would have great influence over them. Is there anything that other police forces across the world are doing, other Governments or other regional governments?

Jane Powell (Chair, Campaign Against Living Miserably): The Londonderry prevention programme is something that we would really like to see happen in London. It is quite a complex programme but it addresses real-time data and also supports and identifies the community affected. It would be really good to see that adopted within London.

Unmesh Desai AM: What is the name of the programme you refer to?

Professor David Mosse (Chair, Haringey Suicide Prevention Group): It is based in Londonderry. Details can be passed on. It is a community response to suicide, an interagency programme and a set of protocols.

Jane Powell (Chair, Campaign Against Living Miserably): Agencies like the police and Network Rail are and have been focusing upon suicide prevention for a long time. What is clear from their work and from the work across the country is that there really needs to be joined-up, co-ordinated work between all of the local authorities. That does happen to a various extent within London.

We would also really love the opportunity to be able to signpost to Londoners who are calling or on webchat to local agencies across London but we cannot do that right now. We would love the opportunity to take more of those calls and webchats. At the moment the only funding we get is tri-borough. The overwhelming majority of funds that we get are from the public, particularly in London, who would like to see this issue addressed.

Dr Tamara Djuretic (Public Health Consultant, London Borough of Haringey): There are a number of good practices across England and the world. In the east of England you have Merseyside and Cheshire - they have zero-suicide policies - and also Boston and Washington in the United States of America (USA). For all of them - echoing what we are talking about - it is about a multiagency response. It is about quite a lot of resources being put into this as well. It is also about having a very comprehensive approach to suicide prevention, from the community response that we talked about all the way to health services and then across suicide plans. We are happy to share those plans with you. It is thinking about what is realistic and what the strategic and political ambition is for London to do that. All of these plans have been comprehensively put in place and there are a number of implementations. None of them have actually managed to completely reduce suicide or eliminate it. Therefore, it is about political aspiration and ambition to stretch us to do more than what we are doing at the moment, which is the question for London.

We have recently also visited New York. There is significant funding from the Mayor's department on public health in terms of mental health, something that cannot really be matched in this country. We need to be realistic as to what is the added value to London from what is already happening. For me, I have already raised three points that would add value.

Professor David Mosse (Chair, Haringey Suicide Prevention Group): During the coming year the National Institute for Health and Care Excellence has set up a public health committee on suicide prevention in the community and in custody, extending to look at the problem of rising suicides in prisons. This will be a piece of work that examines the evidence for various different approaches and public health initiatives and will be producing guidelines in early 2018. Paying very careful attention to those guidelines and ensuring that they are followed would be the obvious thing to do.

Dr Paul Plant (Deputy Director, Public Health England (London)): To pick up the international comparison, you have to be really careful because, wherever you look, nobody else has the NHS. Therefore, whatever we think about where the NHS is at the moment, access to treatment and care tends to be better than privately funded systems in other parts of the world. We have to be really careful when we think a lot of investment has gone into something. It looks like a lot of investment has gone into it and that is because we would not necessarily look at that significant investment in the NHS. When you look at the different budgets you have to be very clear.

I get the sense across the world that there is a growing realisation that there is a highly preventative element to this. I understand that we need part of the focus on suicide but there are a lot of people in mental distress where we know what works. That is where we need a broader, longer-term strategy. We have had this conversation. The rates are going down even if we have some question as to whether they are accurate rates. There is a well of people in London suffering from a lot of mental distress. If you are asking for a pan-London sense of leadership, that has to be multi-sectoral and a coalition. You question whether Public Health England needs to do that. We cannot do that alone but we can do that with others.

For me, one thing I would pick out of all of the myriad other things we have talked about is a deepening understanding amongst our public servants about spotting, understanding and reacting; also, permission and a deepening understanding amongst Londoners that some of the things they experience are normal and some of the things they are experiencing are a rational response to some real hardships. If you have been abused, having a mental health problem is probably quite a rational response to that. There are all of these other things happening.

What I have noticed in the time I have worked in London is that there is growing awareness. I know of a lot of work with the Metropolitan Police Service working with mental health trusts about crisis and about what you do with people in crisis. That is fantastic work. I have seen some great work by the London Underground with their staff spotting people on the edges of the platform. I have seen stuff happening with National Rail about some of our big transport hubs where the numbers are going down. You track the numbers of people committing suicide in a mental health setting, the numbers are going down. Over a period of time the question is whether it is fast enough and focused enough.

I come back to Tamara's [Djuretic] point, which is that we could all think of a fantastic response to this but the issue is one of prioritisation and resourcing. If local government is not resourced and the NHS is not resourced, the nature of the prioritisation is getting harder and harder because the implications are getting bigger and bigger. We need to have a sense of a bigger strategy here.

Dr Onkar Sahota AM (Chair): Thank you. We are wrapping up now, remember. The Mayor has been in the position for about six months now. What work has been undertaken by the Mayor's team so far to deliver the manifesto commitment he has to co-ordinate efforts to reduce suicide rates in London? What has he done so far and what does he intend to do?

Amanda Coyle (Assistant Director, Health and Communities, Greater London Authority): I have mentioned that we did have a suicide prevention and reduction roundtable in August. This fits within a wider piece of work relating to mental health. There will be an announcement in December [2016] on that.

Over and above that, we have been working with a huge variety of agencies to help inform our work on mental health. It is everybody from the third sector to local authorities, the police, Network Rail, the Royal National Lifeboat Institution, the Samaritans and so forth. We do recognise that as part of our health and equality strategy this is an area we need to look at. This work is being looked at under the mental health work stream we are pursuing as officers here within the GLA. We hope to make an announcement by the end of the year.

Dr Onkar Sahota AM (Chair): What resources is the Mayor going to commit to his strategy for reducing suicide in London?

Amanda Coyle (Assistant Director, Health and Communities, Greater London Authority): As everybody on the panel has alluded to, this has to be a system-wide approach if we are going to be able to make any impact.

Dr Onkar Sahota AM (Chair): My question is a very specific one rather than a vague one. What resources is the Mayor going to commit to the strategy?

Amanda Coyle (Assistant Director, Health and Communities, Greater London Authority): We need to be able to take a system-wide view and also to build out a strategy from that to be able to understand what resources are required from this building as distinct from local authorities and the third sector.

Dr Onkar Sahota AM (Chair): At the moment there is no commitment for any resources at all?

Amanda Coyle (Assistant Director, Health and Communities, Greater London Authority): There is a very firm commitment to be able to look at a strategy that will deliver a reduction in suicides and within that to understand the value-add that the Mayor can bring as distinct from duplicating anything that the local authorities, Public Health England or the NHS is doing. We really do think it is very important. It also links back into the Mayor's work on social integration, on community engagement and the work of Matthew Ryder

[Deputy Mayor for Social Integration, Social Mobility and Community Engagement] in terms of understanding what needs to happen within the communities to make this turnkey improvement in reducing suicides.

At the moment I cannot answer that question in terms of what resources the Mayor is going to personally commit. All I can say is that there is a commitment to make sure that we have a strategy to be able to reduce suicides.

Andrew Boff AM: You are saying there is going to be an announcement in December on a mental health strategy. Will you commit to giving the Chair of the Committee forward notice of that? Thank you very much.

Amanda Coyle (Assistant Director, Health and Communities, Greater London Authority): [Nod]

Dr Onkar Sahota AM (Chair): Amanda, how will you measure the success of the work you have done? What will be the markers of success? How will you measure the success of the strategy you will be putting forward?

Amanda Coyle (Assistant Director, Health and Communities, Greater London Authority): That is a really tricky one. The panel have really illustrated that today. Clearly the absolute number is the most obvious one, but we have heard from Jane [Powell] today that pulling together a strategy that has an incredible number of community players buying into it is going to be absolutely key to making sure it is a prevention strategy and that we can get to the root causes of suicide.

I do not have the answer. It is something where we will need to work with and across the system to be able to see what type of proxy measures we need to put in place to see whether our strategy is working. That could be the number of additional calls that fantastic third sector organisations, like Jane's, take in terms of signposting to services that are available, all the way through to some of the great work that you have pointed to in terms of what needs to happen within communities. As I say, I do not have the answer on that but that is very much at the heart of the work that we need to do.

Dr Onkar Sahota AM (Chair): Detroit [USA] has a strategy of zero suicides as a measure of its success. That was one of the international programmes you were looking at. That is the measure they have in Detroit: zero suicides. It will be interesting to see what measures the Mayor of London puts up to measure his successes.

This is to all the guests. What can the Mayoralty and the various organisations do to help the boroughs enhance their suicide prevention activities? What can we do to help them deliver on their obligation or intention to have suicide strategies?

Professor David Mosse (Chair, Haringey Suicide Prevention Group): The contrast between an integrated approach as opposed to a specialist approach on suicide prevention is in some sense a false distinction. What is significant about a focused approach is that it is holistic. What is special about having a focused approach is that you make sure all the different players come together and so in fact it is the most integrated of all approaches.

We should avoid the question of whether it is integrated into wider mental health services or is separate. The whole point about the guidance given by Public Health England, for example, on developing suicide prevention plans is precisely about widening the picture and making sure that suicide is everybody's business. That lies behind the ambition - and it is an ambition - of those who talk about zero suicide.

Dr Onkar Sahota AM (Chair): Yes, thank you. If you feel later on that you need to add something, have forgotten to say something or want to add to our discussions, please feel free to write to us. We are happy to receive information. Send all the information that we have asked for but, if anything else comes to your mind that you think would be very useful information for the Committee, please do send it in. Thank you very much for your contributions this morning.

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GREATERLONDONAUTHORITY LONDONASSEMBLY

Subject: Summary List of Actions

Report to: Health Committee

Report of: Executive Director of Secretariat	**Date: 12 January 2017**

This report will be considered in public

1. Summary

1.1 This report sets out details of completed and outstanding actions arising from a previous meeting of the Health Committee.

2. Recommendation

2.1 **That the Committee notes the completed and outstanding actions arising from a previous meeting.**

Minute item	Subject and action required	Status	For Action
6	**Suicide Prevention in London (Item 6)** During the course of the discussion, the Committee requested the following additional information:		
	• Data on how the suicide rate in London compares with that of other UK cities;	**Ongoing.** The Chair has written to request this information.	Deputy Director, Public Health England
	• Forward notice of the mental health strategy announcement due to be made by the Mayor in December 2016; and	**Ongoing.** The Chair has written to request this information.	Assistant Director of Health and Communities, GLA
	• Details of the suicide prevention programme adopted in Londonderry, Northern Ireland.	**Completed.** Further information has been provided through following links: • Developing Community Response Plans in Northern Ireland;[1]	Chair, Haringey Suicide Prevention Group

[1] http://suicideprevention.salvos.org.au/wp-content/uploads/2012/09/Barry-McGale-Suicide-Prevention-Strategy.pdf

Minute item	Subject and action required	Status	For Action
		• Exploring a Community Response to Multiple Deaths of Young People by Suicide;[2] and • Western Health and social Care Trust: Family Liaison Service.[3] It was also suggested that Members look at the experience in county Durham in piloting an early alert system linked to support to those affected by suicide, and at other Local Authorities' suicide liaison services, such as Outlook SW,[4] based in Cornwall.	
	Authority was delegated to the Chair, in consultation with the Deputy Chairman, to agree any output from the discussion.	**Ongoing.**	Scrutiny Manager
7	**Health Committee Work Programme (Item 7)** Authority was delegated to the Chair, in consultation with the Deputy Chairman, to agree the scope and terms of reference for the review of issues relating to disability and mental health.	**Not used.** Scope to be formally agreed at **Agenda Item 5.**	n/a

[2] https://www.qub.ac.uk/research-centres/CentreforChildrensRights/filestore/Filetoupload,485912,en.pdf
[3] http://www.westerntrust.hscni.net/services/2027.htm
[4] http://www.outlooksw.co.uk/suicide-liaison-service/

Meeting on 19 October 2016

Minute item	Subject and action required	Status	For Action
6	**Transport for London's Role in Promoting Health in London (Item 6)** During the course of the discussion, the Director of Surface Strategy and Planning, Transport for London (TfL) undertook to provide the Committee with: • A copy of the terms of reference for TfL's internal Health Action Plan Board; and • Further information on TfL's policy for placing defibrillators at stations; and • Assurance that health considerations would be written into the next draft of the Mayor's Transport Strategy. During the course of the discussion, the Chair of the Faculty of Public Health's Health Improvement Committee undertook to provide the Committee with a copy of the Faculty of Public Health's report on local action to reduce the health effects of cars.	**Completed.** Letter to the Chair from the Director of Surface Strategy and Planning, TfL is attached at **Appendix 1.** **Ongoing.** The Chair has written to request this information.	Director of Surface Strategy and Planning, TfL Chair of the Faculty of Public Health's Health Improvement Committee

List of appendices to this report:
Appendix 1 - Letter to the Chair from the Director of Surface Strategy and Planning, TfL.

Local Government (Access to Information) Act 1985
List of Background Papers: None

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Transport for London

Surface Transport

Transport for London
11th Floor
Palestra
197 Blackfriars Road
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Dr Onkar Sahota AM
Chair of the Health Committee
City Hall,
The Queen's Walk,
London,
SE1 2AA

02 December 2016

Dear Onkar,

London Assembly Health Committee, 19 October 2016

Thank you very much for inviting me to the London Assembly Health Committee meeting to discuss our role in promoting health in London, and for your subsequent letter of 31 October. This is an important issue and we welcome the Health Committee's focus on it.

My responses to the Committee's requests are set out below.

Healthy Streets Steering Group Terms of Reference

Please find enclosed a copy of the terms of reference of the Healthy Streets Steering Group. As we discussed at the meeting, we are currently building the Healthy Streets approach into the governance systems of our organisation as this work programme evolves. The role and terms of reference of the steering group will be kept under review as part of this work.

TfL's policy on defibrillators at stations

We are one of many organisations working closely with the London Ambulance Service (LAS) to provide defibrillators where they are most needed across the capital. There are currently 213 defibrillators on the London Underground (LU); located at 148 stations across the network. 52 of these are in Zone 1 stations, with some larger stations having more than one machine. 83 of the locations were installed by the London Ambulance Service (LAS) and 65 locations were installed by us. All the defibrillators are maintained by us and can be accessed by customers. Please see the enclosed map for the locations.

The location and number of machines at any one station is specified by the LAS in conjunction with NHS guidance. LAS take into account a number of factors, including history of incidents, customer footfall, geographical layout

and density of crowds at certain times. Machines are generally also installed at the busiest stations, or where there have been previous incidents. In setting out to install defibrillators, we took advice from the LAS about the best locations to install the machines. LAS provided us with data and, based on this data and our own records, a heat map was produced that highlighted the most common places where customers were taken ill on our network. In addition, they are strategically placed to enable quieter stations on our network, such as West Finchley Tube station, access to a machine in an emergency. We will continue to work closely with the LAS to provide defibrillators where they are most needed.

Further to this, over the last few years, all LU Customer Service Advisors (CSAs) have attended one day emergency first aid courses as part of their continuous development programme. These first aiders regularly provide treatment for customers and there are many examples where this has made a considerable difference in the event of a customer being taken ill or being injured. LU and LAS also run two hour defibrillator workshops for those CSAs that work at stations that have a machine. Defibrillators are also designed in a way that formal training is not required.

Assurance that health considerations will be written into the Mayor's Transport Strategy

You also asked for reassurance that health will be written into the next Mayor's Transport Strategy. As you know, the Mayor made it clear in his 'A City for All Londoners' document his vision is to create Healthy Streets across London to help improve the health and quality of life of all Londoners. The document makes clear that improving health will be a central theme in his new transport strategy.

Yours sincerely

Ben Plowden
Director of Surface Strategy & Planning

1 Objective

1.1 The Deputy Mayor for Transport has requested that TfL embed the Healthy Streets approach (as set out in the TfL Health Action Plan 2014) into decision making across the organisation to deliver improvements in the 10 Healthy Streets outcomes. The Healthy Streets Steering Group has been established to provide governance to the process of embedding the Healthy Streets approach across TfL and coordinating TfL's partnership working with GLA teams, boroughs and other external stakeholders..

2 Members

2.1	**Chair:**	Ben Plowden	(Director, Surface Strategy & Planning)
	Members:	Tim Steer	(GLA Transport Team)
		Lilli Matson	(Head of Strategy & Outcome Planning)
		Lucy Saunders	(Public Health Specialist, TfL / GLA)
		Sam Monck	(Head of Borough Projects and Programmes)
		Nigel Hardy	(Head of RSM Sponsorship)
		Chris Mather	(Head of Behaviour Change)
		Lisa Taylor	(Interim Chief of Staff to MD, Surface)
		David McNeill	(Director of Public Affairs & Stakeholder Engagement)
		Kristy Marshall	Head of Press Desk - Policing, Cycling, Streets & Freight (PCSF)
		Simon Nielsen	(Head of Strategic Analysis)
		Lucinda Turner	(Acting Director of Borough Planning)
		Tom Layfield	(GLA Transport Team)
		Alex Phillips	Bus Policy Manager
	Secretariat:	John Futcher / Andy Summers, Cycling Team, Strategy and Outcome Planning	

2.2 Additional attendees may be invited to attend for particular issues which are under consideration.

2.3 Substitutes will be able to attend in the event of a member not being available.

3 Terms of reference

3.1 To oversee the strategic direction of and coordinate the delivery of a programme of work to embed the Healthy Streets approach across TfL activities including strategic planning, surface transport, communications (internal and external) and London Underground.

3.2 To coordinate the interface of TfL's Healthy Streets activities and announcements with TfL's partner and stakeholder organisations

3.3 To approve and coordinate specific announcements and key milestones, including the publication of the Healthy Streets Vision and associated documents

3.4 To review and approve key TfL decisions related to embedding the Healthy Streets approach across the organisation.

3.5 To identify and manage/resolve interdependencies, interfaces, conflicts or gaps with or between other TfL projects/programmes and the Healthy Streets approach.

3.6 To ensure the embedding of the Healthy Streets approach is adhering to pathway, good governance, TfL policies & standards and legislative obligations.

3.7 To review risks to delivering the Healthy Streets approach and to a) note specific mitigation activities and b) agree and pursue corporate activities.

3.8 To assign any delegated authorities and ensuring the appropriate levels of empowerment exist within portfolios and project teams.

3.9 To direct the work of ***a Healthy Streets working group***, comprising TfL officers from across TfL who are responsible for developing and delivering the individual programmes and announcements that collectively comprise the 'Healthy Streets' programme.

4 Frequency of meetings

4.1 The Steering Group should meet once every two to three weeks until January 2017, or as requested by the Chair.

4.2 From January 2017 meeting frequency should be reviewed.

5 Quorum

5.1 Core attendees may nominate alternates to ensure attendance at these meetings.

5.2 The quorum will be the Chair and three other members or their substitutes. In the absence of the Chair, the meeting will be chaired by a substitute nominated by the Chair prior to the meeting.

6 Inputs

6.1 A programme plan for tracking key milestones and deliverables across the full range of embedding activities.

6.2 Presentations or papers on specific issues which require decisions / approvals.

6.3 Fortnightly progress update from the Working Group.

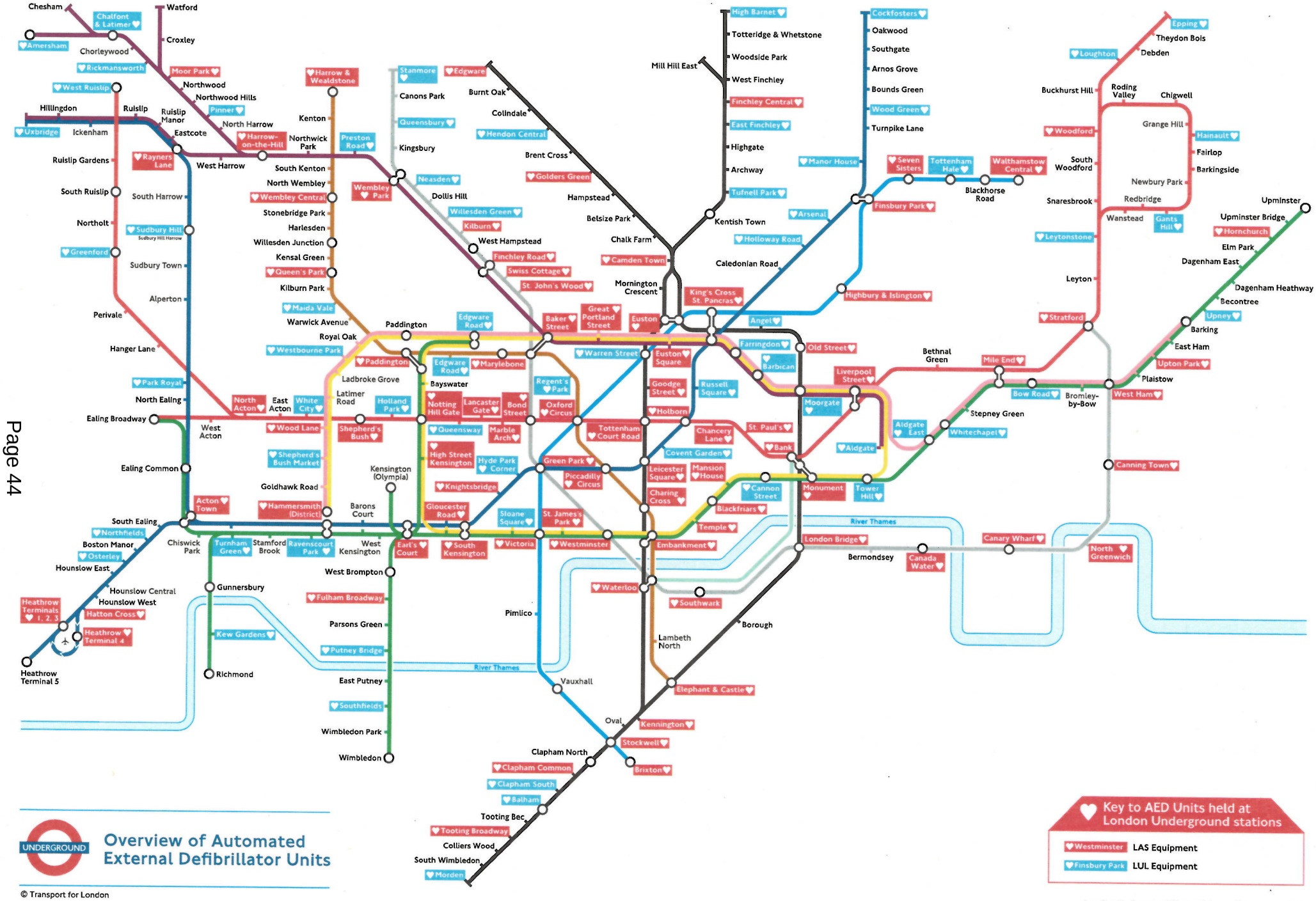
7 Outputs

7.1 Minutes of each meeting recording the main actions arising and decisions made.

8 Other matters

8.1 At least annually, or when the Healthy Streets agenda progresses to the next stage in its life, the Steering Group will review its Terms of Reference, membership and Chair.

8.2 The Chair and membership of the Steering Group will depend on the stage of the programme and may change as the programme progresses.



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UNDERGROUND

Overview of Automated External Defibrillator Units

Key to AED Units held at London Underground stations

Westminster — LAS Equipment

Finsbury Park — LUL Equipment

London Underground Control Centre (November 2014)

GREATERLONDONAUTHORITY LONDONASSEMBLY

Subject: Mental Health and Disabled and Deaf People

Report to: Health Committee	
Report of: Executive Director of Secretariat	**Date: 12 January 2017**
This report will be considered in public	

1. Summary

1.1 This report sets out background information and context to the Committee's discussion with external guests on mental health and Disabled and Deaf people.

2. Recommendations

2.1 **That the Committee agrees the scope for its review into mental health and Disabled and Deaf people outlined at Appendix 1 to this report.**

2.2 **That the Committee notes the report as background for the discussion with invited guests and notes the subsequent discussion.**

2.3 **That the Committee delegates authority to the Chair, in consultation with the Deputy Chairman, to agree any output from the discussion.**

3. Background

3.1 The Chair and Deputy Chairman have agreed to use this meeting of the Health Committee to discuss mental health and Disabled and Deaf people with a panel of invited guests.

4. Issues for Consideration

Remit of the discussion

4.1 The meeting forms part of a series of Health Committee sessions looking at mental health inequalities for marginalised groups. This meeting will focus on the experience of service users. It will seek to determine the specific challenges faced by Disabled and Deaf people in accessing appropriate mental health support in London and what the Mayor could do to support better access to these services.

4.2 The Committee is recommended to delegate authority to the Chair, in consultation with the Deputy Chairman, to agree any output from the discussion at this meeting.

Invited Guests

4.3 Guests invited to the session include:

- Richard Holmes, Policy manager, Royal National Institute of Blind People;
- Roger Hewitt, Chair, British Society for Mental Health and Deafness;
- A representative from a pan-London disability charity;
- Alessandro Storer, Equality Improvement Manager, MIND; and
- A representative from the Association of Directors of Adult Social Services (ADASS).

5. Legal Implications

5.1 The Mayor of London's statutory responsibilities in relation to health matters, as set out in the Greater London Authority (GLA) Act 1999, are to develop a strategy which sets out "proposals and policies for promoting the reduction of health inequalities between persons living in Greater London". The GLA Act 1999 defines health inequalities as inequalities between persons living in Greater London "in respect of life expectancy or general state of health which are wholly or partly a result of differences in respect of general health determinants" and also goes on to define "health determinants". The Mayor of London has no statutory role in the commissioning of any health services or health service provision.

5.2 Officers confirm that the scope for this review falls within the Committee's terms of reference.

5.3 The Committee has the power to do what is recommended in the report.

6. Financial Implications

6.1 There are no financial implications arising from this report.

List of appendices to this report:

Appendix 1 – Scoping paper for the Health Committee's review into mental health and Disabled and Deaf people

Local Government (Access to Information) Act 1985 List of Background Papers: None	
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Health Committee meeting

Deaf and Disabled people and mental health

The Health Committee is planning to use its January meeting to look at Deaf and disabled people and mental health. The meeting forms part of a series of Health Committee sessions looking at mental health inequalities for marginalised groups. This paper sets out a proposed scope for this part of the investigation.

Purpose

The purpose of this meeting is to determine:

- What are the key mental health challenges facing Deaf and disabled people; and
- How the Mayor and the GLA can support better mental health for Deaf and disabled people in London.

Background

Around 14 per cent of adult Londoners have a disability – equating to around 1.1 million people. Types of impairment range from physical and mobility impairments, sensory impairments, learning disabilities, cognitive impairment and long term mental ill health resulting in disability. Many disabled people have more than one impairment.

Eight out of 10 people with a physical impairment weren't born with it. The vast majority become impaired through an injury, accident, heart attack, stroke or conditions like MS and motor neurone disease. There is also growing recognition of the impact of long-term conditions such as heart disease and diabetes, which can lead to physical impairment including loss of mobility. Similarly, the majority of people with a sensory impairment develop this over their life course.

Studies have shown that Deaf and disabled people are more likely to experience common mental health problems, especially anxiety and depression. For example, Deaf people are twice as likely to suffer from depression as hearing people, and around one in three people with chronic physical impairment experience a mental health problem, compared to one in four in the wider population. The links between disability and mental health are extremely complex, but are increasingly recognised to be inherently linked to how wider society, including the health and care sector, treats disabled people.

Deaf and disabled people have shared experiences of exclusion and discrimination because of their impairment. But the specific ways in which they are excluded or discriminated against - barriers each group of disabled people face - can be different according to the access needs different impairments create.

Deaf and disabled people have reported a number of barriers to accessing mental health support. These include:

Attitudinal barriers: these are cultural and social attitudes and assumptions about people with impairments that explain, justify or perpetuate prejudice, discrimination and exclusion from society. In a clinical context, these can include assumptions that a mental health issue is the direct result of an impairment, that disabled people are unable to live independently or make decisions/choices about their health and care, that disabled people need 'protecting', or that people with impairments want to be 'cured'.

Information and communication barriers: This can include lack of British Sign Language interpreters for Deaf people, lack of provision of hearing induction loops, lack of information in different accessible formats such as 'Easy Read', Plain English and large font or failure to provide people with more time to take in and absorb information. This also includes lack of provision of inclusive and accessible messaging around how to maintain positive mental health and wellbeing.

Environmental barriers: In a mental health context this can range from physical inability to access buildings (or transport to get to them), to lack of access to the wider determinants of mental wellbeing, such as adequate and appropriate housing, suitable employment, and poverty.

More broadly, organisations highlight a basic lack of joined-up thinking between mental health services and physical health services, with mental health services being ill-equipped to deal with people with physical or sensory disabilities, and physical disability services lacking awareness of mental health needs and support options. However, there is comparatively little data available, especially at a London level, on how Deaf and disabled people view the services available to them or what improvements they would like to see.

The role of the Mayor and the GLA

The Mayor has a statutory duty to produce a strategy to promote the reduction of health inequalities among Londoners, including mental health inequalities.

Mental health is one of the key priority areas for the London Health Board, chaired by the Mayor. The Board has recently agreed to develop a 'mental health roadmap' for London. The roadmap is intended to shine a spotlight on public mental health and galvanise the system to improve support for people experiencing mental illness to play an active role in life in London, including supporting the most vulnerable.

The Mayor's manifesto includes a number of pledges to improve life chances for people with disabilities including tackling disability hate crime and supporting the development of, and protection of, schemes which expand opportunities for people with disabilities to work and gain skills.

Aims of the review

This investigation will seek to determine the specific challenges faced by Deaf and disabled people in accessing appropriate mental health support in London. The findings will seek to influence the development of the Mayor and London Health Board's mental health roadmap, to ensure that the roadmap reflects the needs of all Londoners and helps to tackle mental health inequalities. It will seek to encourage greater partnership working amongst pan-London and local stakeholders to improve the mental health offer for Deaf and disabled Londoners.

Impact category	Evidence of impact
Challenging	Challenging misconceptions, adding to research evidence base for future studies.
Engaging	Working with stakeholders from under-represented groups
Influencing	Recommendations/findings form part of the mental health roadmap and future mayoral work in this area, including the Health Inequalities Strategy refresh.

Deaf and Disabled people and mental health

Suggested approach

The Committee will hold one meeting with invited guests to discuss this topic. Potential guests include:

- Roger Hewitt, British Society for Mental Health and Deafness;
- Inclusion London;
- RNIB;
- Disability Rights UK;
- SignHealth; and
- Academic institution e.g. Disability research Centre Goldsmiths University or Centre for Disability Research, Lancaster University.

Key questions

The Committee will examine the following key questions:

- What are the specific mental health challenges faced by Deaf and disabled people in London?
- What are the main barriers for Deaf and disabled people when trying to access mental health support?
- What specialist mental health support is available for Deaf and disabled people. What more is needed?
- How can mental health services make themselves more inclusive and accessible to Deaf and Disabled people?
- What examples of good practice are there, in London and further afield?
- What can be done to promote positive mental wellbeing and build mental health resilience for Deaf and disabled people?
- How can wider policy initiatives (housing, transport, policing) help improve mental health for Deaf and disabled Londoners?
- What can the Mayor do to support better mental health for Deaf and disabled Londoners?

Output

A letter or short report to the Mayor summarising the findings to inform the development of the Mayor's mental health roadmap.

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GREATERLONDONAUTHORITY LONDONASSEMBLY

Subject: Health Committee Work Programme

Report to: Health Committee	
Report of: Executive Director of Secretariat	**Date: 12 January 2017**
This report will be considered in public	

1. Summary

1.1 This report sets out proposals for the Health Committee Work Programme.

2. Recommendations

2.1 **That the Committee agrees the proposals for the Health Committee work programme.**

2.2 **That the Committee agrees to use its meeting on 15 March 2017 for a discussion on issues relating to mental health support for ex-offenders and people released from prison.**

2.3 **That the Committee delegates authority to the Chair, in consultation with the Deputy Chairman, to agree the scope and terms of reference for the review of issues relating to this topic.**

3. Background

3.1 The Committee receives a report monitoring the progress of its work programme at each meeting.

4. Issues for Consideration

4.1 The Committee's calendar of meetings for 2016/17 was agreed at the Assembly's Annual Meeting on 13 May 2016. The remaining meeting slots for the Committee in 2016/17 are set out below:

15 March 2017	19 April 2017

4.2 Provisional areas for further Committee work this year include:

- Mental health: The final session on mental health will be a meeting on mental health for ex-offenders (dates to be determined); and
- The Mayor's Health Inequalities Strategy: the Committee will consider using a formal meeting slot to discuss matters relating to the revision of the Mayor's Health Inequalities Strategy, to

inform the Committee's response to the formal consultation.

4.3 The scope, approaches and timings for the work in these areas will be determined as the work programme evolves, and the Committee will consider detailed scoping proposals for any new investigation undertaken in separate reports. Evidence may be gathered through formal Committee meetings, informal briefings, site visits, rapporteur projects, engagement events or a combination of approaches.

5. Legal Implications

5.1 The Mayor of London's statutory responsibilities in relation to health matters, as set out in the Greater London Authority (GLA) Act 1999, are to develop a strategy which sets out "proposals and policies for promoting the reduction of health inequalities between persons living in Greater London". The GLA Act 1999 defines health inequalities as inequalities between persons living in Greater London "in respect of life expectancy or general state of health which are wholly or partly a result of differences in respect of general health determinants" and also goes on to define "health determinants". The Mayor of London has no statutory role in the commissioning of any health services or health service provision.

6. Financial Implications

6.1 Any project related costs (eg transport costs arising from any site visits) will be met by the Scrutiny budget. There are no other direct financial implications to the Greater London Authority arising from this report.

List of appendices to this report: None.

Local Government (Access to Information) Act 1985 List of Background Papers: None.	
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