NHS
Hampshire and Isle of Wight
Sustainability and Transformation Partnership

Suicide Prevention Programme

November 2019 update

MOVING FORWARD TOGETHER

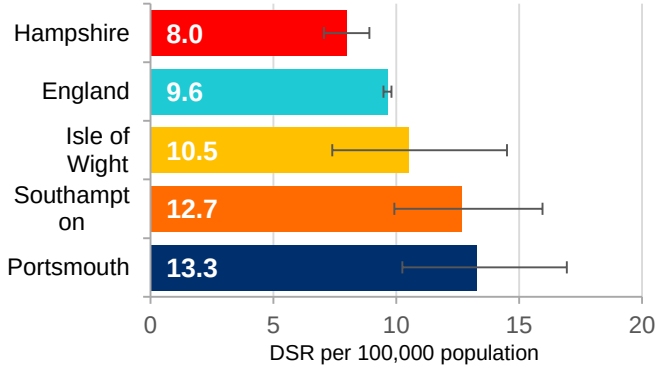
Local data – numbers over stated period

PHE Fingertips data, suicide prevention profile. Data from Office for National Statistics (based on date of registration) for 2016-18.

- Hampshire 287 (average of 96 per year)
- Isle of Wight 39 (average of 13 per year)
- Portsmouth 68 (average of 23 per year)
- Southampton 78 (average of 26 per year)

Local data – rate per 100,000

Mortality from suicide and injury undetermined - Persons DSR per 100k - HIOW STP Local Authorities: 2016-18:



Source: Public Health England

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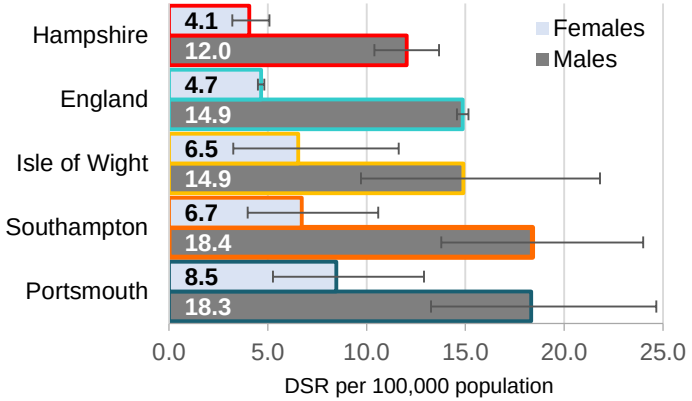
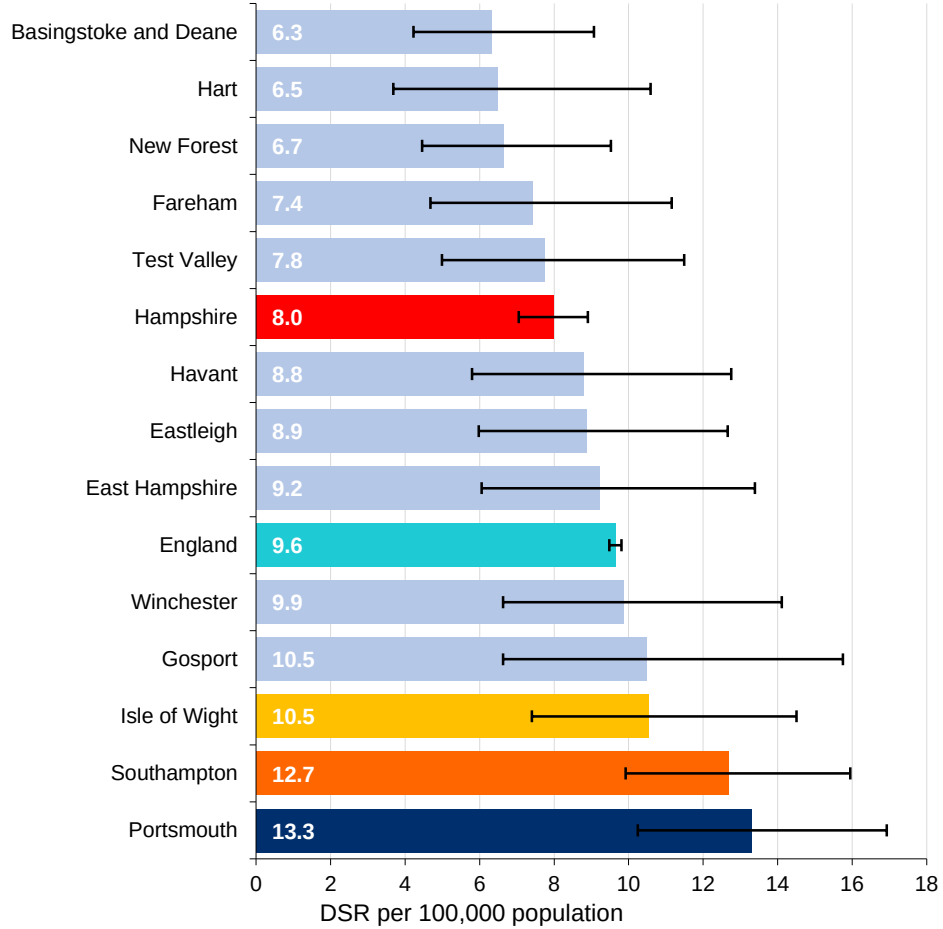


Source: Public Health England

Mortality from suicide and injury undetermined (persons) DSR per 100k HIOW STP Districts: 2016-18



Sources: Public Health England

HIoW local suicide audit analysis

Each PH team currently records and analyses suicide data in slightly different ways. The key themes from collective analysis are:

- Mental health and relationship issues were the most common recorded adverse life events.
- Illness, bereavement, addiction and financial worries (including debt) were also common antecedents to suicide.

Key lessons to be learned were identified as:

- People not in contact with ‘formal’ services.
- Poor risk assessments/note keeping (including potential precursory events) and onward sharing.
- Poor communication between and with services/agencies/partners:
  - Continued partnership approach to suicide prevention is crucial.
  - Requirement for improved cross-system communication and shared learning.
  - Referral processes and discharge protocols.
- Services, organisations and support groups require clarity on resources available to them and availability of appropriate training.
- Lack of family and carer involvement.
- Time allocation, management and follow-up with DNA/’difficult to engage’ patients.
- Inconsistent data recording and coding.
- Transition processes e.g. CAHMS to AMH.

National guidance

Suicide prevention is often only seen as an issue for MH Services, yet around two thirds of people who take their own lives aren't in contact with MH Services in the year before they die.

Evidence based risk factors:

- Men (men are three times more likely to die by suicide than women).
- People in the age group 40-44 years.
- People in the care of MH Services.
- People with a history of self-harm.
- People in contact with the Criminal Justice System.
- People bereaved or affected by suicide.
- People living in areas of higher socioeconomic deprivation.
- People who are unemployed.
- People working in least skilled occupations (e.g. construction workers).
- People with a low level of educational attainment.
- People who do not own their own home.

NHS England areas of focus

In 2012 the government published ‘Preventing Suicide in England: A Cross Government Outcomes Strategy to Save Lives’.

This strategy identified six key areas for action:

- Reduce the risk of suicide in key high-risk groups.
- Tailor approaches to improve mental health in specific groups.
- Reduce access to means of suicide.
- Provide better information and support to those bereaved by suicide.
- Support the media in delivering sensitive approaches to suicide and suicidal behaviour.
- Support research, data collection and monitoring.

The Suicide Prevention National Transformation Programme was established in response to a national commitment to reduce deaths by suicide by 10%, by 2020/21. This programme includes £25m of transformation funding to support targeted local areas to reduce suicide rates and self harm.

Hampshire & IoW STP is a second wave STP and received funding of £468,000 in May 2019.

NHS England areas of focus

There are three areas of focus for the programme, based on evidence provided by NCISH (National Confidential Inquiry into Suicide and Safety in Mental Health) about the highest levels of need:

- Men (particularly those aged 35-54) – they have the highest incidence of deaths by suicide
- People who use mental health services – around one third of people who die by suicide are in contact with services
- People who have self-harmed – they are at increased risk of death by suicide.

NHS England have set the following criteria for delivery:

- Prevention beyond secondary services:
  - place-based community prevention work targeting;
  - middle-aged men; and/or
  - primary care support.
- AND/OR
- Reduction within services via quality improvement: self-harm care within acute hospitals and/or generally within mental health services. This should account for people with diagnoses of personality disorder.

HIoW approach and process

Principles informing HIoW recommendations:

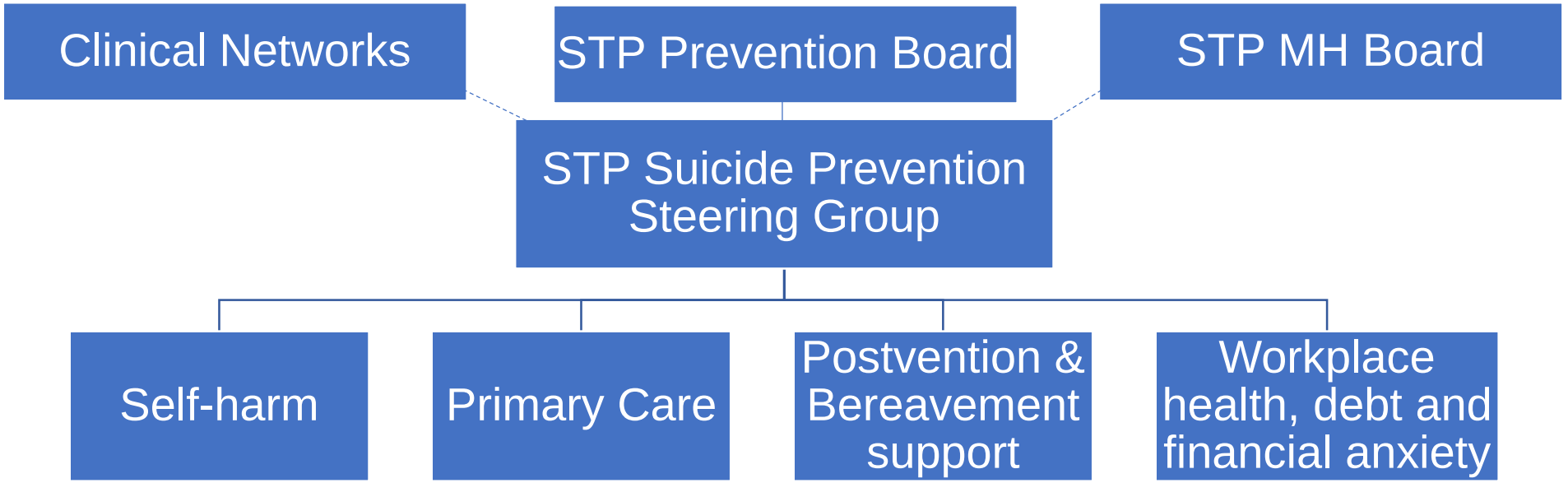
- Sustainability: beyond the initial guaranteed 12 month period of funding.
- Added value
  - Improving quality and/or equity.
  - Over and above commissioned services / ‘business as usual’ and/or increasing scalability.
  - Adding value to existing suicide prevention actions at local level.
- Early intervention and prevention
  - Promoting protective factors for suicide and/or self-harm, addressing key risk factors.
  - Consider interventions across different settings and including the wider determinants.
- Evidence based (or to inform the evidence base)
  - Informed by intelligence, published literature and/or stakeholder views.
- Universal approach with additional support for vulnerable groups.
- Life-course approach where appropriate.

HIoW approach and process

Initial scoping for each of the four priority areas for HIoW:

- Two Tasks and Finish groups delivered for each of the four priority areas.
- Task and Finish Groups attended by partners working across the system.
- Aim of Task and Finish Groups:
    - Scope unmet needs and prioritise to make recommendations for how STP suicide prevention funding should be best spent.
- Additional meetings for self-harm with service providers and commissioners.
- “Bottom up” approach.
- Triangulated recommendations with the data, intelligence and evidence base.

HIoW governance



Postvention & bereavement support

Evidence

- Around 800,000 people a year are affected by suicide.
- People bereaved by suicide are at 65% higher risk of attempting to take their lives, and around 9% of those bereaved make a suicide attempt.

Objectives

- Real-time surveillance data allows for identification of high-risk groups, individuals and locations.
- Key partners are informed of suspected suicides in a timely way and are able to put in place appropriate postvention support.
- Everyone that would like bereavement support knows what is on offer and how to access support, and that support is available in a timely manner.
- Equity of service provision: proactive and reactive tailored support providing emotional support for next of kin and wider family, as well as wider groups affected e.g. workplaces.
- The voluntary and community sector providing consistent support across the STP geography.

Postvention & bereavement support

Status in HIoW

- Hampshire Police have instituted a real-time surveillance system, providing monthly reports to PH teams.
- There is no current universal provision of bereavement support across the STP. Hampshire Police will refer to SOBS (Survivors of Bereavement by Suicide) and Red Lipstick Foundation as well as providing Help is at Hand booklet and seeking consent to share contact details with bereavement services.
- Postvention support (within 48-72 hours) is not currently in place across the STP, but efforts are being made to ensure there is a standardised postvention protocol for suspected suicides of young people and/or of those within schools or college communities.

Solutions

- Develop and implement a timely STP-wide real-time surveillance and notification system that incorporates key partners. Create standardised operating procedures for postvention activity by key partners.
- Identify/develop central hub(s) of consistent information relating to suicide bereavement (e.g. Hub of Hope, NHS Trust websites etc.). Consistent, well communicated pathways for different people/needs (e.g. group vs. one-to-one support).
- Map and link existing provision of bereavement support, improving capacity and capability across needs.
- Linking real-time surveillance to suicide audit data collection, and wider unexpected deaths processes/data collection and analysis (e.g. drug related deaths).

Workplace health, debt & financial anxiety

Evidence

- Low-skilled male labourers are three times more likely to take their own lives than the national average. Other groups with an increased risk are nursing staff, primary teachers and agricultural workers.
- Workplace stress, job insecurity, zero-hour contracts and workplace downsizing are important risk factors.

Objectives

- Improve awareness of suicide prevention amongst targeted high-risk employers and employee groups.
- Identify key business service organisations that can multiply reach of this initiative and support the self-employed.
- Promote best-practice and provide employers with access to the skills and resources required, including crisis response plans.
- Co-produce appropriate resources and approach with key employers.
- Support workplaces to navigate approach to improving mental wellbeing and suicide prevention in the workplace (phased, low-resource approach).
- Incorporate financial literacy and access to financial advice and support, as well active sign-posting to support organisations.
- Build on available resources and existing good practice.

Workplace health, debt & financial anxiety

Status in HIoW

- A number of initiatives operate across HIoW:
  - Hampshire Step-by-Step men's mental health programme.
  - Job Centre Plus suicide prevention training for staff.
  - Southampton & Portsmouth Time to Change Hub.
  - Southampton CC Wellbeing at Work.
  - CAB collaboration with Southern Health to support people with poor mental health access CAB support.
  - MIND Workplace Wellbeing programme.
  - Samaritans work with ports.

Next steps

- Identify key target organisations and employee groups across HIoW. Identify levers across the system to help engage target audiences (including use of voluntary and community sector organisations, grassroots organisations, sports clubs etc.).
- Research best-practice employers and approaches to high-risk groups (e.g. middle-aged men) and industries.
- Work with key stakeholders e.g. Citizens Advice Bureau, MIND etc. to improve access to financial advice for key target groups.

Primary Care

Evidence

- Many people who take their own life are in contact with their GP in the months before they die, with estimates ranging from 32-66% in the month leading up to their death and 75% in the six months before.

- A Samaritans and Centre for Mental Health research paper highlights 5 key areas in need of improvement:
  - Education and training: there is a consensus that education is crucial to suicide prevention.
  - Primary Care practice and staffing: therapeutic relationships between patients and their GP needs to be a priority.
  - Emotional support for GPs; many GPs are not getting the support they need with their own emotional wellbeing, particularly following the death of a patient by suicide.
  - Effective care pathways for people who are feeling suicidal: there is little evidence of effective pathways between primary care and both clinical and social support.
  - Ease of making referrals and accessing further support: many GPs face considerable challenges referring patients on for further support. These include high thresholds for eligibility, variation in availability of services and lack of access to expert advice.

Primary Care

Solutions

- Training (suicide prevention, self-harm and bereavement support)
  - Embed suicide prevention training and a “train the trainer approach” in GP trainee training.
  - Develop and deliver local suicide prevention training for primary care clinicians; using a combination of face-to-face and webinar training (learning from the pilot of 4MH training for primary care staff in Hampshire and Southampton).
  - Promote free online training to the non-clinical workforce.
  - Focus on improved practices and actions taken (e.g. use of safety plans) as a result of training.
- Resources
  - Suicide prevention and self-harm resources: ensure that existing good quality suicide prevention and self-harm resources are easily accessible to professionals, and embedded in their processes.
  - Take learning from other areas and across the STP, e.g. Southern Health’s use of Stay Alive app and ‘Every Life Matters’ cards.
- Data quality and communications
  - ED coding of attempted suicides and self harm: potential audit of ED coding for attempted suicides and self-harm to support identification of issues and recommendations.
  - Review of communication practices between Primary & Secondary care regarding referrals, discharge etc.

Self-harm

Evidence

- 170 times greater risk of suicide (than general population) in the month after attending A&E with self-harm injury.
- 50 times greater risk of suicide (than general population) in year after attending A&E with self-harm injury.
- Approximately two thirds of self-harm injuries don't end up in A&E/Hospital.
- Nationally only c.60% of A&E self-harm attendees receive a psychosocial assessment.

Objectives

The factors behind self-harm are varied and complex, and may require different interventions depending on target demographic and stage of intervention (e.g. following A&E attendance vs. population-wide). This programme will initially focus on three priority areas:

- Post-A&E discharge to address the significantly increased risk of suicide. This will look at referral mechanisms (and recipients of referrals), best-practice interventions/therapies and how existing STP practices can be improved and strengthened.
- Prevention. An initial focus on better understanding self-harm across the STP - what A&E/Psychiatric Liaison data tells us, the prevalence of self-harm in non-A&E settings, and the core issues that lead people to self-harm, particularly for CYP. An improved understanding of self-harm pathways and underlying issues will assist in targeting interventions at those most in need and/or where biggest impact can be achieved.
- There is an abundance of resources available on self-harm and our approach will seek to maximise their use, focussing on accessibility and utility – what is available and where, what will change as a result of using these resources, how can they be embedded within everyday practice and how can we measure any impact of their use.

The programme will also be escalating some issues for national discussion, such as the potential role of algorithms that embed protective messages in social media.

Self-harm

Approach

- To be sustainable interventions must integrate with existing structures and complement wider initiatives. Scoping conversations have included CAMHs and workforce development (particularly DBT capacity across the STP), resilience training for CYP in schools (resilience being a key protective factor for self-harm and attempted suicide) and resilience training for families/carers (equipping families and carers with key proactive skills such as family communications skills, and the knowledge, skills and confidence to be able to support their child's mental heath and emotional wellbeing needs).

Status in HIoW

- Self-harm pathways are being developed by local PH teams.
- Wessex CYP MH Steering Group working on LTP, crisis care, access to mental health services and workforce development.
- HEE Workforce Development programme, HEE's competency framework and self-harm resources such as Health Talk and Health in Education Settings.
- MHSTs being established in a number of schools (not covering the whole STP).

Next steps

- Review existing self-harm data, gaps and data requirements, working with partners to address gaps in data and understanding of self-harm.
- Linking local data to self-harm pathway development work to understand intervention points and potential for value add – taking learning from other STPs and best-practice.
- Develop relationships across wider stakeholders, e.g. Ambulance service, Schools/Colleges, voluntary and community sector organisations etc. to identify partners for delivery and sustainment.
- Linking with the Primary Care programme strand on self-harm data collection and ensuring self-harm is incorporated in future PC training.

Measurement and evaluation

- There is a national commitment to reduce the number of deaths by suicide by 10%, by 2020/21. It is not possible to attribute specific interventions to a reduction in the number of suicides at an STP level.

- Each project will have a set of defined target outcomes and output measures to evaluate their impact and effectiveness.

- The programme will be incorporating a ‘Quality Improvement’ approach with PDSA cycles (Plan, Do, Study, Act) to test approaches locally before wider implementation.

- Through improvements to the real-time surveillance system, we will be reporting on suspected suicide numbers for the STP in addition to business as usual annual suicide audit reporting (based on date of registration).

Next steps

- Agree broad approach outlined above and arrangements for updates/decision making
- Develop and finalise driver diagrams
- Outline business case/options paper for each of the four programme areas, covering:
  - High-level delivery plans and milestones
  - Governance and stakeholders (incorporating local suicide prevention arrangements)
  - Ways of working across the STP
  - Stakeholders
  - Budget outline
  - Measures and evaluation
- STP Steering Group meeting – January/February 2020 (date TBC)
  - Agenda: Presentation and discussion of high-level delivery plans