

Regional Suicide Prevention Steering Group

**A 5 Year Strategy for Suicide
Reduction and Prevention**

**Final Version
Neil Johnson
May 2010**

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Executive Summary

- In 1999, *Saving Lives* established a target date of **2010** for a **20% reduction in the suicide rate** (from the baseline set for the years 1995 - 1997)
- As 2010 is now upon us, the suicide rate within the **North East** remains high at **8.5 per 100,000** population (compared to the rate for England of 7.8 per 100,000). This has reduced from the baseline figure of 9.9 per 100,000 thus equating to a reduction of 14.3% (15.2% nationally) but more needs to be done
- According to *New Horizons*, the intended replacement for the National Service Framework for Mental Health, suicide prevention remains a key public health issue
- A multi-agency Suicide Prevention Steering Group has been established to progress this agenda within the North East. This **5 year strategy** is a product of the group's early work
- It is our intention to ensure that, **by 2015**, the suicide rate within the **North East** has reduced from its current rate of 8.5 per 100,000 population to the national average for England (currently **7.8 per 100,000 population**)
- If we use the Office for National Statistics 2007 estimate of population for the North East of **2.6 million people**, this would equate to a reduction of **18 cases per year** (from 221 suicides to 203 cases)
- Based on a Health Economy model developed for the Northern Ireland Suicide Prevention Strategy where each case was estimated to cost the regional economy **£1.4 million** (see 1.11), this would mean a **saving** to the regional economy of approximately **£25.2 million**
- The strategy is structured into a series of *Key Processes* and *Key Developments* which we intend to take forward over the next 5 years. These are as follows:

<i>Key Processes</i>	<i>Key Developments</i>
Data on Suicide	Contact with GPs/Primary Care/Acute Care
Knowledge Transfer	Self-Harm pathways
Commissioning	Suicide Hotspots
Governance Arrangements	Prescribing issues
Training	Lesbian, Gay, Bisexual & Transgender issues
Management of Suicide Clusters	Working with the media
Management of Serious Untoward Incidents	Police, Prisons, Probation and Youth Justice issues

- In addition, the Steering Group has suggested a number of priorities to be progressed **in year 1 (2010/2011)**. These are as follows (with the reference section/page of the strategy in brackets):
 - Quantifying the economic cost of suicide (section 3/page 16)
 - Develop multi-agency information-sharing protocols (section 7/page 17)
 - Develop common terms of reference between sub-regional and regional suicide prevention groups (section 11/page 17)
 - Training Needs for Suicide Prevention (section 15/page 17)
 - Develop a regional protocol for dealing with suicide clusters (section 16/page 17)
 - PMS contracts reflect the ongoing management of suicide prevention (section 1/page 18)
 - Development of a Self Harm Pathway (section 2/page 18)
 - Prescribing issues (section 4/pages 19-20)
 - Develop a 'gold standard' pathway between health and criminal justice agencies (section 7/page 20)

Details of Consultation

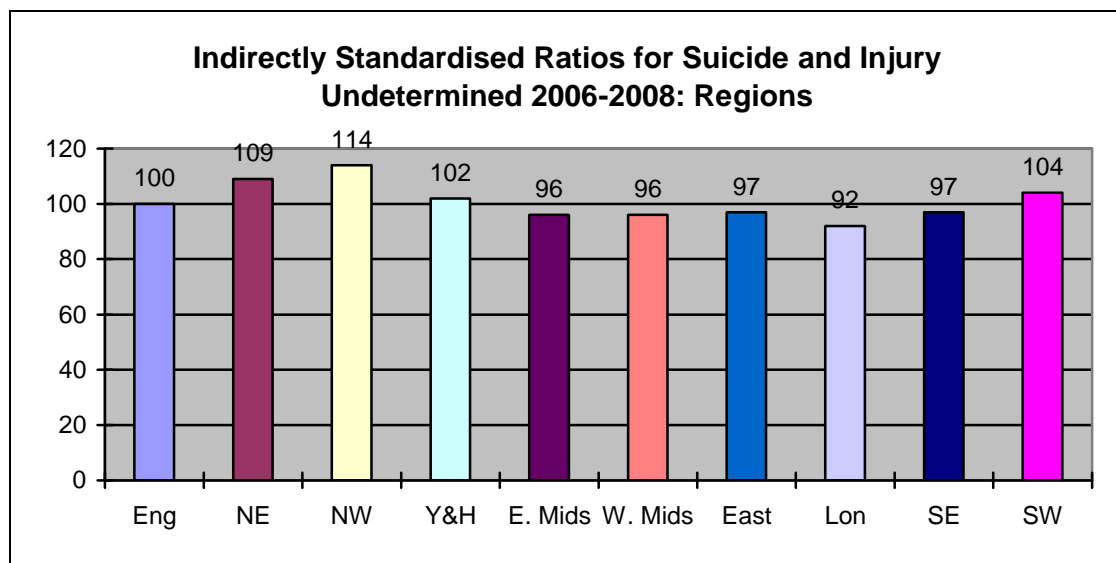
- The Regional Suicide Prevention Steering Group would like to consult on these **year 1** priorities and would welcome comments from anyone with an interest in preventing suicide
- The consultation period will run from **Friday 7th May until Friday 11th June**
- Please direct any comments to the following address:

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1.0 Introduction

- 1.1 In 1999, Saving Lives¹ established a target for the reduction of the suicide rate by 20% by 2010. As we are nearing this target date, it is conceivable that the suicide reduction and prevention agenda may begin to slip down the national and regional policy agenda.
- 1.2 However, New Horizons², the replacement for the National Service Framework for Adult Mental Health, issues a warning that this should not happen. It argues that suicide prevention should remain a vital aim of public health, especially during and beyond a recession. This is particularly relevant bearing in mind recent data from the 2007 Adult Psychiatric Morbidity Household Survey³ where, from a sample of 13,000 adults, 16.7% reported suicidal ideation and 5.6% had attempted suicide.
- 1.3 This appears to be borne out by the current statistics on suicide. According to the NCHOD⁴, the North East has the second highest suicide rate in England, behind the North West. The Indirectly Standardised Ratios (ISRs) per 100,000 population between the years 2006 and 2008 were as follows (where 100 is the average):



- 1.4 The Directly Age Standardised Rates (DSRs) per 100,000 population, over the same period, were as follows⁵:

¹ Department of Health (1999) *Saving Lives: Our Healthier Nation*. London: The Stationery Office

² Department of Health (2009) *New Horizons: towards a shared vision for mental health – consultation*. London: Crown Copyright

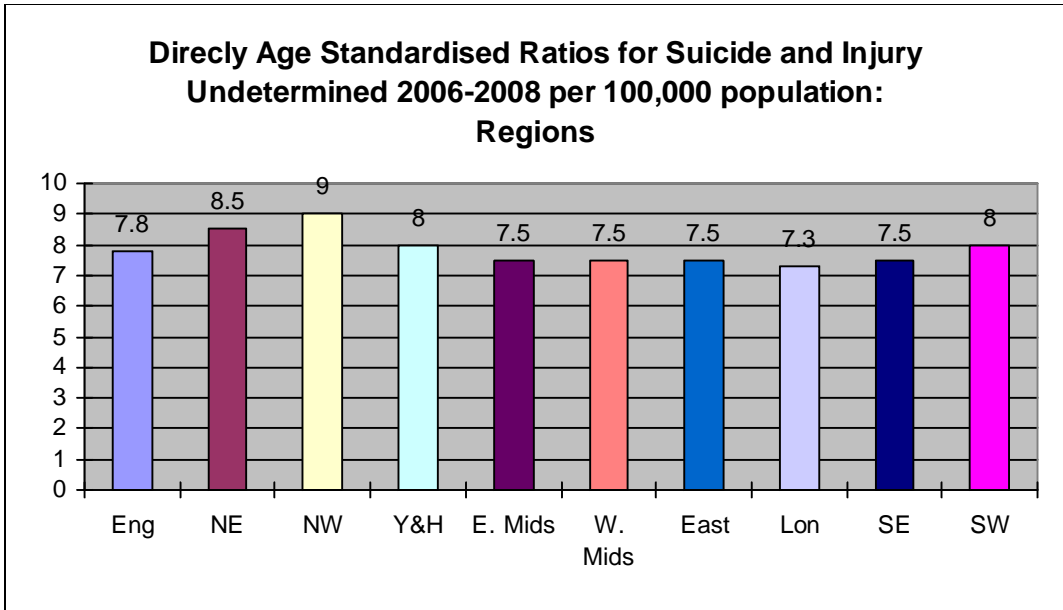
³ <http://www.ic.nhs.uk/pubs/psychiatricmorbidity07>

⁴ National Centre for Health Outcomes Development (2009) *Indirectly standardised ratios (SMR)*. Available at:

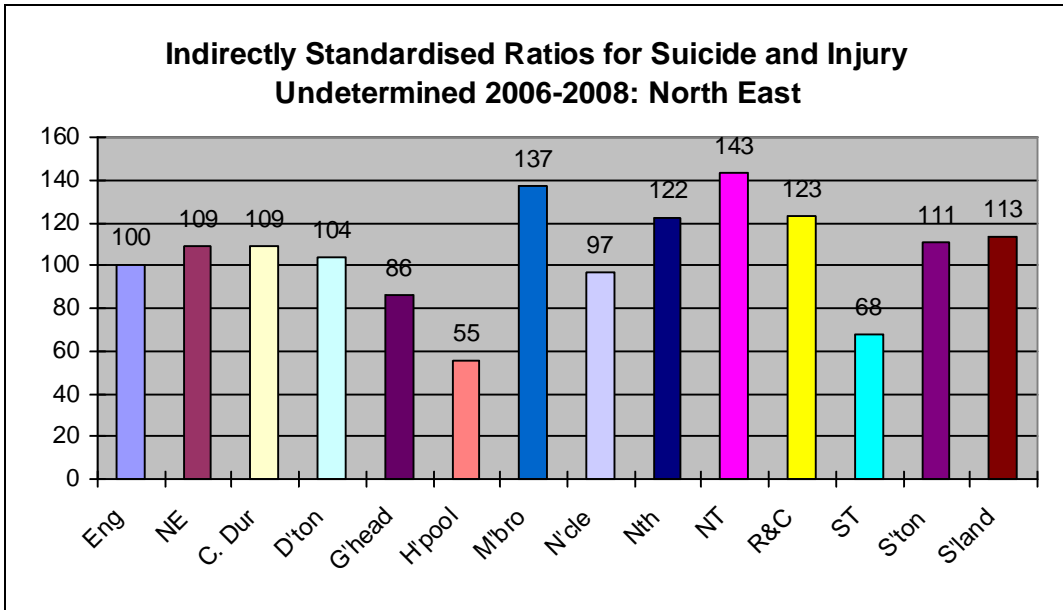
[www.nchod.nhs.uk/NCHOD/compendium.nsf/\(\\$All\)/13E32F36325CF83E802576870040F8A0/\\$File/31D_114SM00++_08_V1_D.xls?OpenElement](http://www.nchod.nhs.uk/NCHOD/compendium.nsf/($All)/13E32F36325CF83E802576870040F8A0/$File/31D_114SM00++_08_V1_D.xls?OpenElement)

⁵ National Centre for Health Outcomes Development (2009) *Directly Age standardised ratios (SMR)*. Available at:

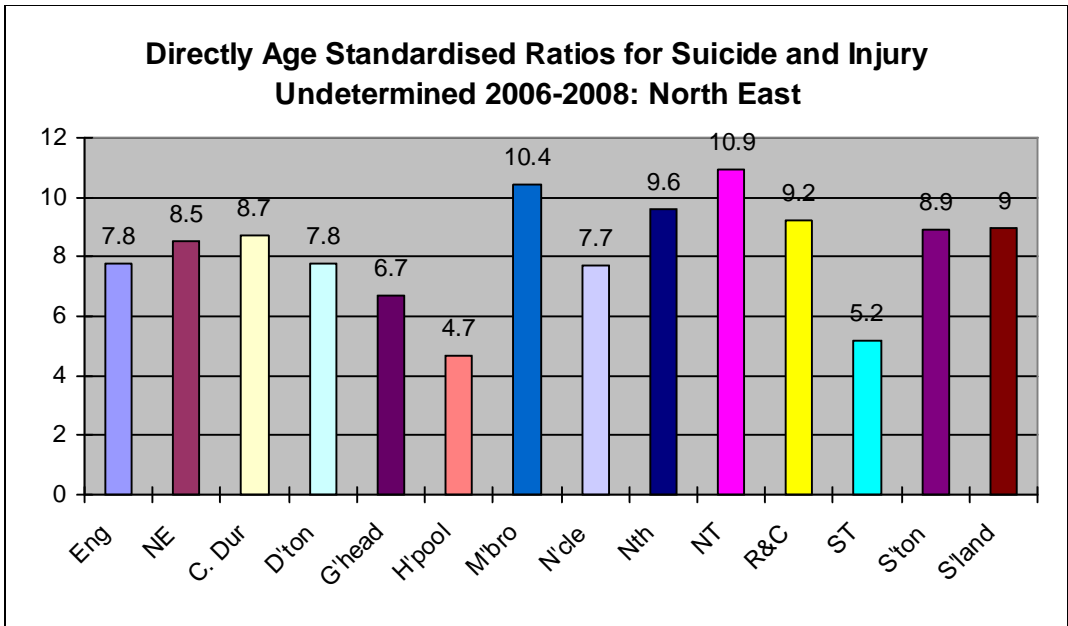
[www.nchod.nhs.uk/NCHOD/compendium.nsf/\(\\$All\)/921BE54BCBA2B628802576870040F8AB/\\$File/31D_114DR00++_08_V1_D.xls?OpenElement](http://www.nchod.nhs.uk/NCHOD/compendium.nsf/($All)/921BE54BCBA2B628802576870040F8AB/$File/31D_114DR00++_08_V1_D.xls?OpenElement)



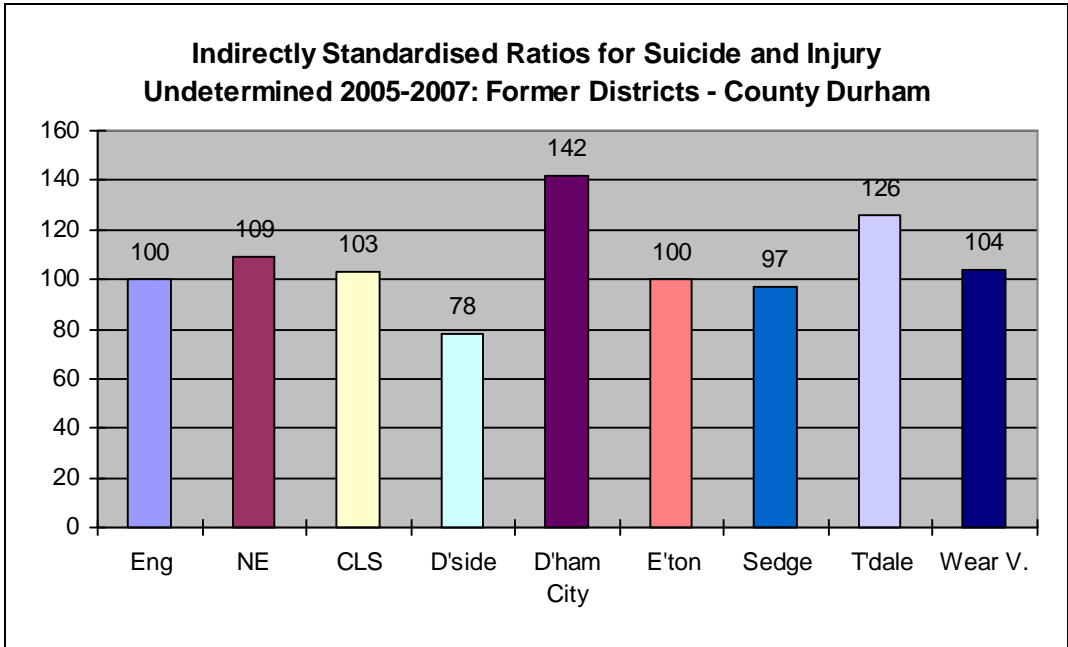
1.5 However, it is within the North East region where the figures are perhaps the most enlightening. The ISRs per 100,000 population between the years 2006 and 2008 were as follows, with 100 being the average (see footnote 3):

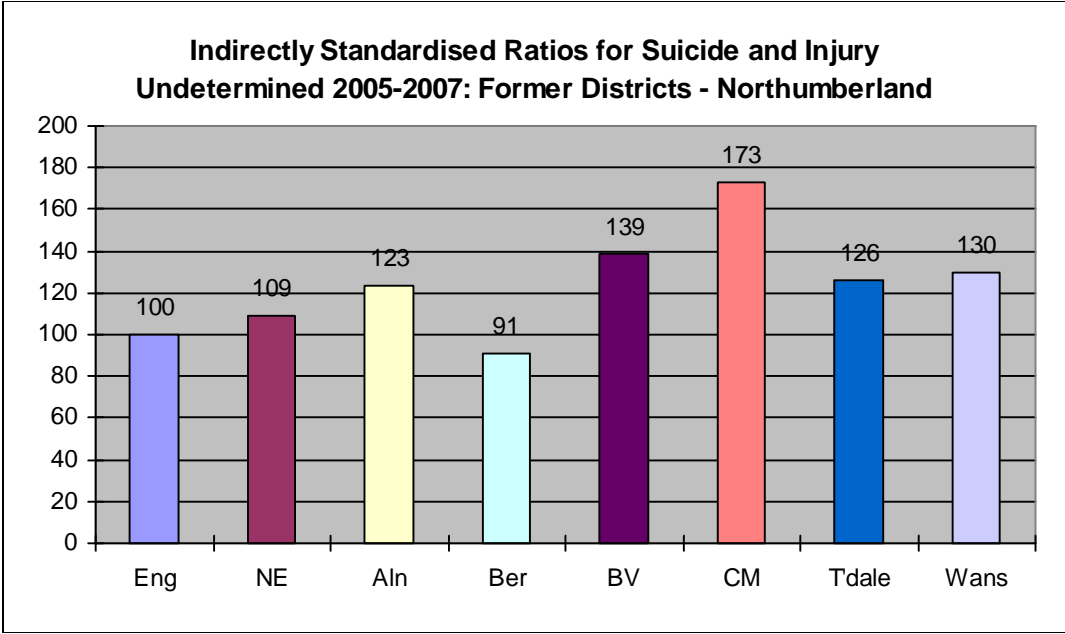


The DSRs per 100,000 population, over the same period, were as follows (see footnote 4):

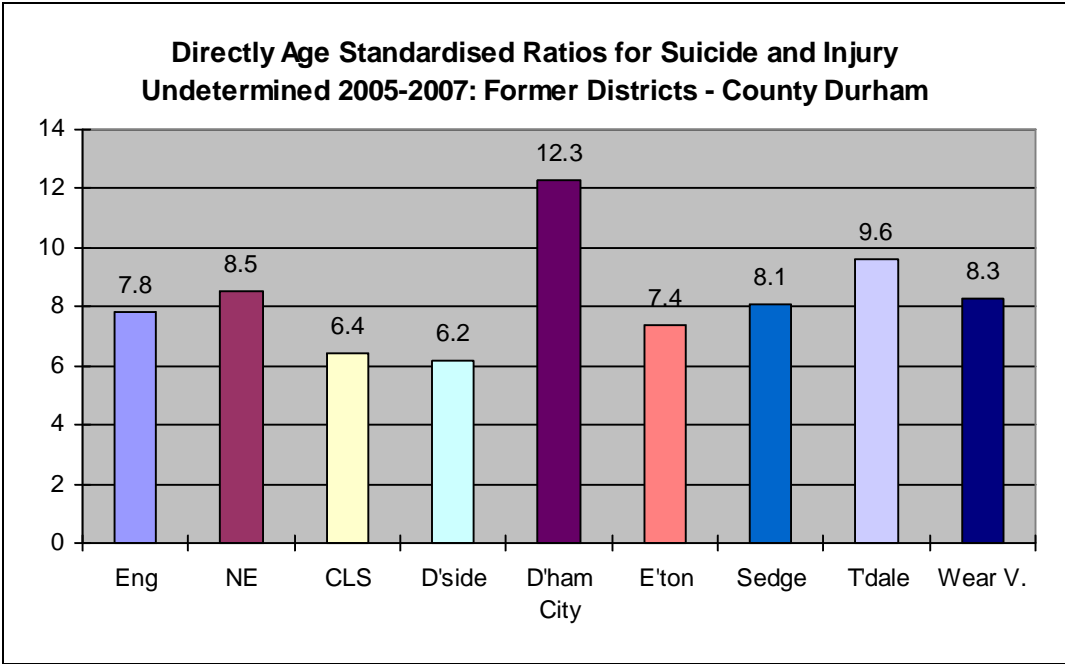


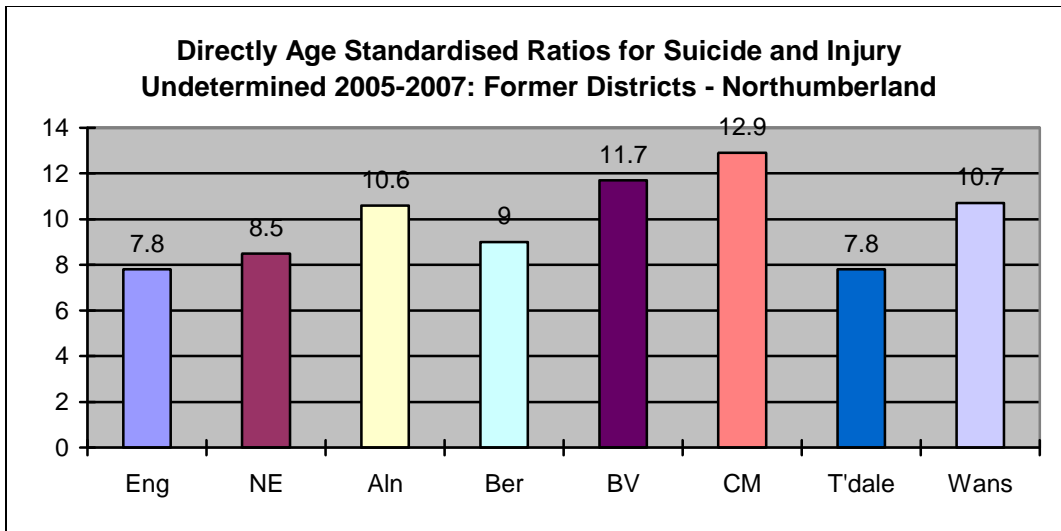
1.6 It is also worth noting figures covering the former District Council areas. The ISRs per 100,000 population, between 2005-07 were as follows, with the average being 100 (see footnote 3):



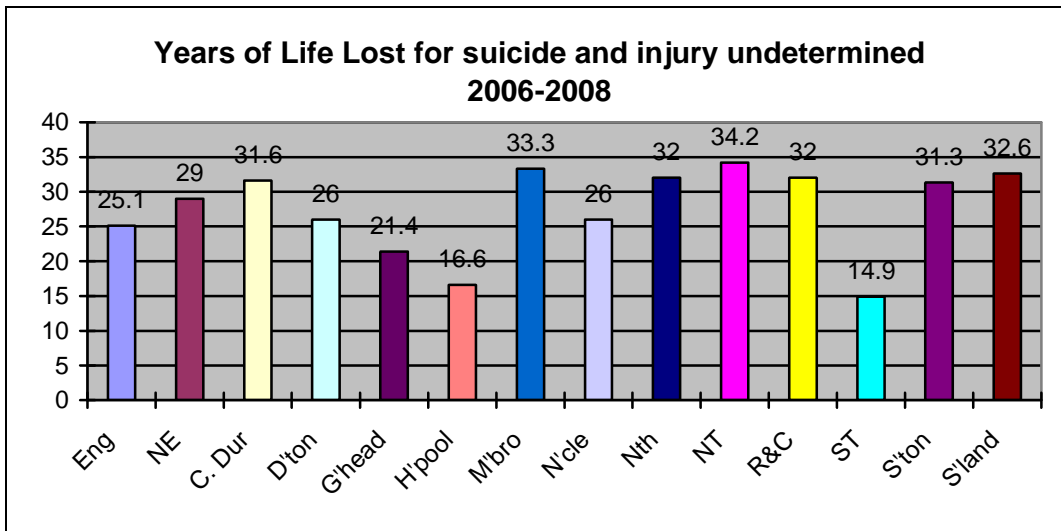


The DSRs per 100,000 population, over the same period, were as follows (see footnote 4):





1.7 If we look further at average Years of Life Lost per case of suicide, the contrasts within the region become more marked. The following are based on an average of 75 years of age between 2006 and 2008⁶:



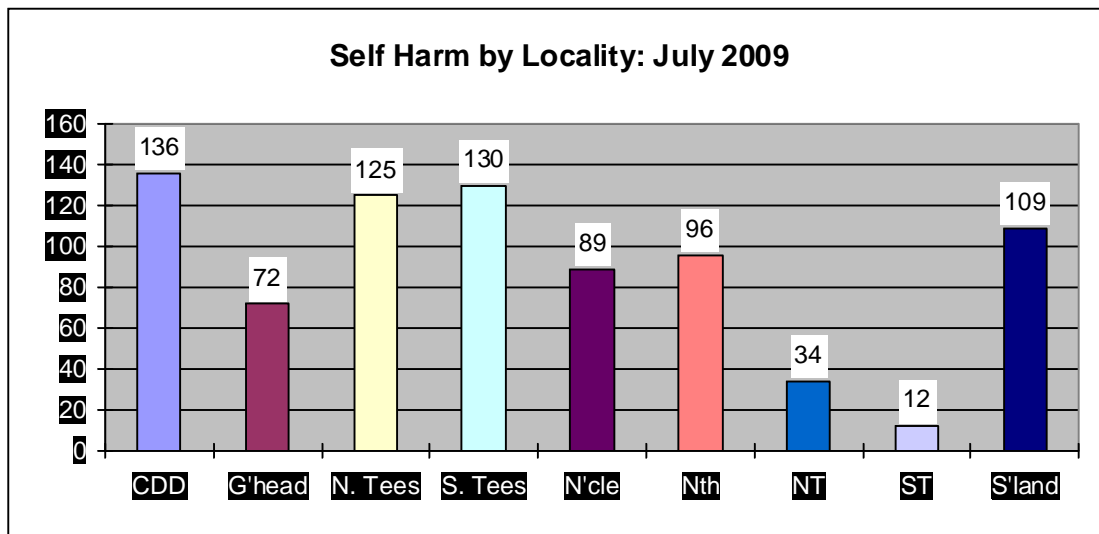
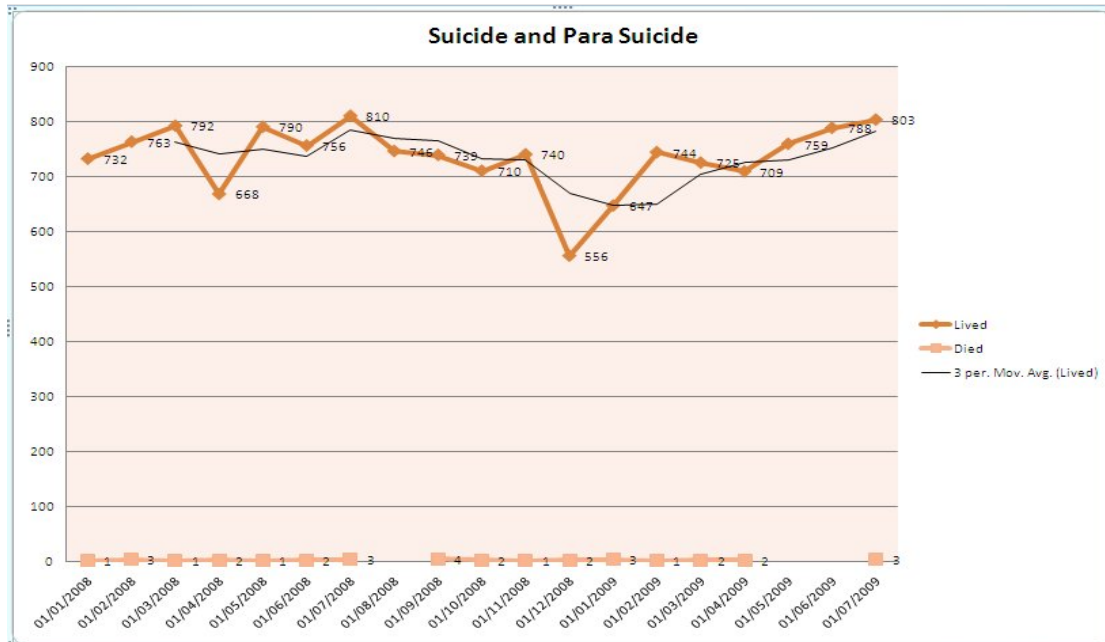
1.8 The data provided in this section are based on figures available from the Office for National Statistics and National Centre for Health Outcomes Development. Data of greater depth are available at a locality level within our region including, in some areas, data on contact with other agencies such as the Police or Primary Care.

However, as the collation of this data varies from locality to locality it would not be appropriate to reflect those figures in this document.

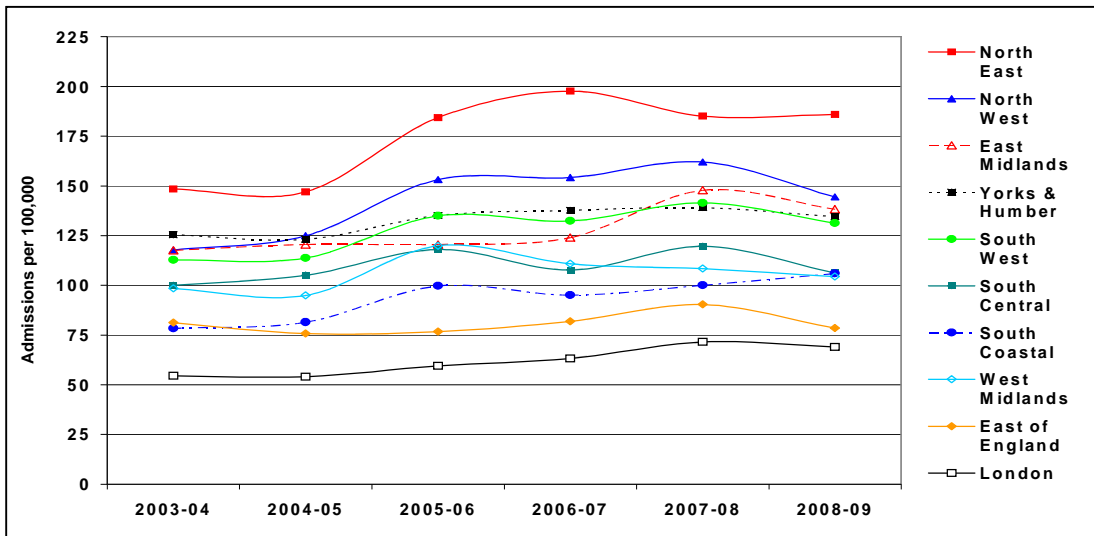
⁶ National Centre for Health Outcomes Development (2009) *Years of Life Lost from suicide and injury undetermined*. Available at: [www.nchod.nhs.uk/NCHOD/compendium.nsf/\(\\$All\)/8E1FB4FAF81A8BDB802576870040F849/\\$File/31M099DR_08_V1_D.xls?OpenElement](http://www.nchod.nhs.uk/NCHOD/compendium.nsf/($All)/8E1FB4FAF81A8BDB802576870040F849/$File/31M099DR_08_V1_D.xls?OpenElement)

It must therefore be a priority for the regional steering group to support and improve the capability of local suicide audit groups to collate data on contact that completed suicides have had with a range of agencies (see Appendix 1).

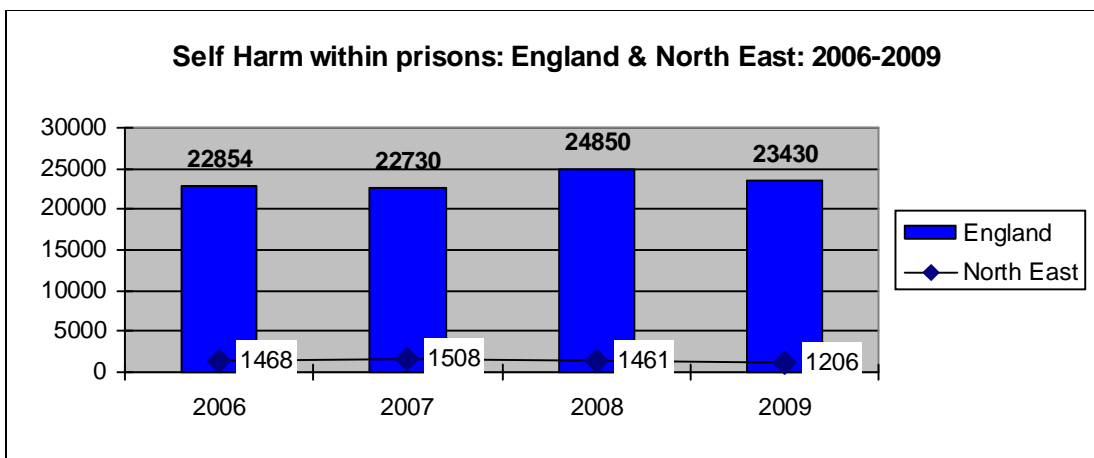
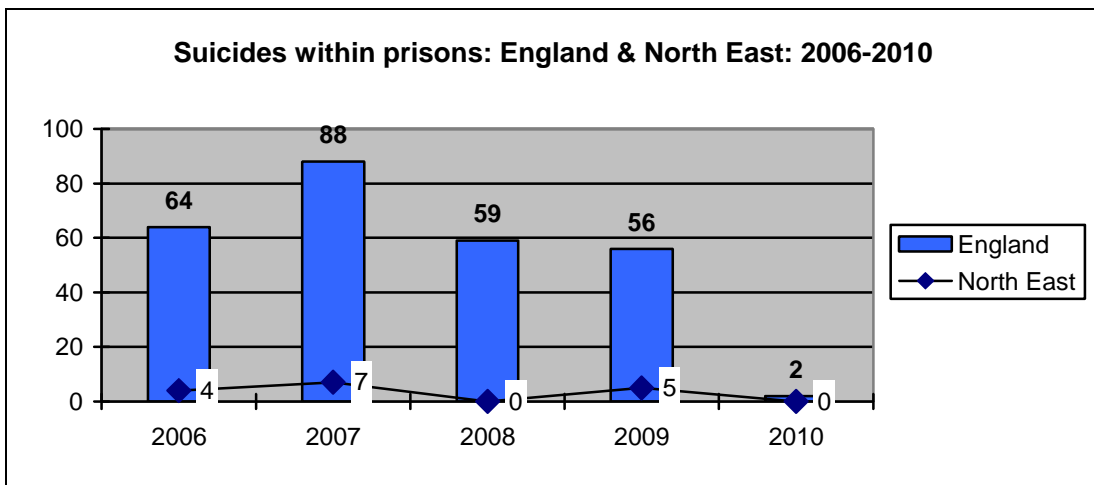
- 1.9 The following visuals examine data on self harm. The data have been taken from Hospital Episode Statistics provided by the CHKS (Caspere Healthcare Knowledge Systems) and based on actual cases presenting at hospital. The data are broken down regionally and by locality for the month of July 2009 (most recently available data)



In addition, the following graph examines: emergency inpatient admissions caused by intentional self-harm, per 100,000 population aged 0-17, by Strategic Health Authority of residence.



1.10 The following tables look at data on suicide and self harm within the prison estate for both England and the North East



- 1.11 The above figures (1.3 to 1.10) demonstrate the human cost of suicide. The Northern Ireland Suicide Prevention Strategy⁷ has gone further to quantify the economic costs. In 2004, there were 146 suicides in the province. This equates to 4350 life years lost at a cost of £1.4 million per case (based on cost of post mortem, loss of earnings and human costs).
- 1.12 In addition, there were 36,000 cases of self-harm in Northern Ireland over a 5 year period. This amounted to 1.46% of all hospital admissions which equated to £6.6 million in lost earnings, hospital costs and other lost output to the Northern Ireland economy.
- 1.13 Something similar for the North East would be invaluable in demonstrating the impact of suicide on the regional economy.
- 1.14 Based upon the above data, it is therefore the contention of this strategy that suicide reduction and prevention remains a major health and social priority that requires multi-agency input within the North East.

2.0 Vision and Rationale

Vision

- 2.1 By 2015, the North East will have reduced its suicide rate to that of the national average for England. Based on current figures (2006-08) this will necessitate a reduction from 8.5 per 100,000 in the North East to the 7.8 per 100,000 rate for England. Based on estimates from the ONS in 2007, where the North East had an approximate population of 2.6 million, this would equate to a reduction from 221 to 203 cases per year

As a secondary objective, by 2015 the North East will work with those localities that have significantly higher rates than the regional average to reduce their rates to that average. This will accommodate those localities identified above in 1.5 to 1.7. Other areas may be added or removed as the data develops.

We will also work with those localities which have low rates of suicide and self-harm to assess the reasons behind their apparent success and, hopefully, translate that success across the region. This may include, for example, undertaking an audit of self harm in a specific locality and/or examining organisational pathways that cases have followed.

Rationale

- 2.2 The Safety First Strategic Framework for the North East⁸ has identified '7 No's' that health services should seek to implement. These include 'No avoidable deaths, injury or illness' with a reduction in the number of suicides being a key driver.

⁷ www.dhsspsni.gov.uk/showconsultations?txtid=15454

⁸ NHS North East (2008) *Safer Care North East*. Available from:

http://www.northeast.nhs.uk/_assets/media/pdf/NW2154_Patient_Safety_Document.pdf

- 2.3 It is therefore imperative that any regional strategy on suicide prevention builds upon this principle by developing a vision that not only reflects a realistic and achievable reduction in suicide from a health service point-of-view but also reflects on the wider impact that suicide has on the general population, individuals and their families and the wider community.

As a regional steering group, we must therefore be seen to lead on and influence others to lead on our behalf.

3.0 Governance Structures

- 3.1 Before looking at the key regional priorities for delivery, it is important to identify the Governance arrangements that will ensure that delivery.

3.2 *National*

At a national level, the National Suicide Prevention Strategy has been operational since 2002. Its primary function is to secure a 20% reduction in the suicide rate by 2010. However, the strategy is approaching its natural end and plans for a refresh have recently been publicised.

At a regional level, it is imperative that we continue to influence the national agenda in areas such as the development of indicators on suicide prevention and on research that will help us to better understand the causes and effects of suicide.

3.3 *Regional*

Within the North East, a Regional Suicide Prevention Steering Group has been established to oversee the development of this 5 year strategy. The Terms of Reference of this group are included under **Appendix 2**.

In addition to this group is a Safer Care Group on Suicide Prevention. This is led by the Strategic Health Authority and relates to the Safer Care North East Strategy, which forms part of the Safety First Strategic Framework for the North East (*see footnote 7*). The focus is very much on preventing suicide within mental health services and, as a consequence, complements the multi-agency nature of this 5 year strategy. The Objectives, Goals, Initiatives and Measures (OGIM) of the Safer Care Group on Suicide Prevention are provided under **Appendix 3**.

3.4 *Sub-regionally and locally*

The region has three sub-regional suicide prevention task forces or groups: Northumberland Tyne & Wear, County Durham and Darlington and Tees-wide. These generally report through Primary Care and Mental Health Foundation Trust performance structures, are multi-agency and multi-professional in focus and have been established to reduce suicide rates within the sub-region. They have all developed strategies and/or plans and are in the process of implementing these.

- 3.5 In addition to these groups are Suicide Audit Groups which tend to operate at collaborative cluster level i.e. North of Tyne, South of Tyne and County Durham/Darlington (Tees operates through the Tees-wide Task Force). Their role is to collate reliable data on suicide and undetermined death and ensure that this data is used to inform local suicide prevention strategies and plans.
- 3.6 However, one significant gap appears to be that there is no mechanism in place for the 3rd sector to receive notification of death even if the suicidal individual has only ever been in touch with that agency.
- 3.7 **Appendix 2** contains a schematic explaining these governance arrangements at a national, regional and sub-regional level.

4.0 Funding

- 4.1 The regional steering group has funding from the North East Mental Health Development Unit (NEMHDU) until the end of March 2010 (£15,000). It has been agreed that this funding should be allocated on the following areas with a view to the translation of the findings across the region:
- Development, implementation and audit of 'gold standard' pathways across Criminal Justice agencies (Tees, Esk and Wear Valley NHS Trust funded £13,000)
 - Assessment of the effectiveness of a Neighbourhood Policing project in Warrington in relation to social inclusive outcomes and reduced suicide rates (Middlesbrough Local Authority funded £2,000)
- 4.2 It is unclear at this stage whether or not NEMHDU will have a budget in 2010/11 to support this work. If such funding becomes available, it is envisaged that the following areas will be prioritised for funding:
- Mapping of multi-agency data on suicide and self harm collated by suicide audit groups with a view to improving the spread of that data and its association with economic factors and indices of deprivation
 - Working with the North East Public Health Observatory to estimate the cost of suicide to the regional economy
 - Funding research to explain the apparently low rates of suicide and self-harm in several localities within the region

5.0 Regional Priorities for Delivery

- 5.1 It is important that this 5 year strategy adds value to existing regional and sub-regional activity by prioritising those issues that are not being taken forward elsewhere and will have the greatest impact. It must also support the delivery of suicide prevention initiatives at a local level.

- 5.2 As a consequence, therefore, the strategic priorities have been split into two sections: *key processes* which are based on the core process issues identified by the Regional Suicide Prevention Steering Group; and, *key priorities* which are based on initiatives to be developed for at-risk groups and for areas of high volume. **Immediate priorities for year 1 are identified in bold text.**
- 5.3 These are covered in more detail in **Appendix 1** where the OGIM framework has been adopted. However, the core themes are outlined below.
- 5.4 *Key Processes*
- Data on suicide
 - Knowledge transfer
 - Commissioning
 - Governance arrangements
 - Training needs for suicide prevention
 - Management of suicide clusters
 - Management of Serious Untoward Incidents
- 5.5 *Key Developments*
- Contact with GP/Primary Care/Acute Care
 - Self Harm pathways
 - Suicide hotspots (including on the transport network)
 - Prescribing issues
 - Lesbian, Gay and Bisexual issues (with a separate focus on Transgender issues)
 - Working with the media
 - Police, Prisons, Probation (including Approved Premises) & Youth Justice issues
 - Other priorities
- 5.6 It is important to recognise that many of these priorities will be informed by the impending Easington Independent Review into Suicide within the locality

Appendix 1: Regional 5 year action plan

OBJECTIVE

To reduce the number of suicides and unexpected deaths within the North East by following a suicide reduction and promotion agenda

GOALS

By 2015, the North East:

1. *Will have reduced its suicide rate to that of the national average for England (currently 7.8 per 100,000 in England; 8.5 per 100,000 North East)*
2. *Will work with those localities that have significantly higher rates than the regional average to reduce their rates to that average*
3. *Will work with those localities that have significantly lower rates than the regional average to understand the reasons behind those low rates*

INITIATIVES: PROCESSES

Data on suicide

1. Work with sub-regional Suicide Audit Groups to assess whether their systems for data collection are fit for purpose and the links they have with other agencies, such as Criminal Justice and Primary Care. Liaise with the Strategic Health Authority to increase the accessibility of such data
2. Use local suicide audit data to identify high risk groups and localities and initiate research in those areas with low rates to explain the reasons behind those low rates
3. **Work with the North East Public Health Observatory to collate data at a regional level and estimate the cost of suicide to the regional economy**
4. Develop robust reporting arrangements to share data with the National Confidential Inquiry into Suicide and Homicide
5. Work with HM Coroners to ensure the timely release of data on possible suicides (share findings from work by David Robinson seconded to TEWV)
6. Work with the Strategic Health Authority and General Hospitals to improve the data collated on self harm

Knowledge Transfer

- 7. Develop information-sharing protocols between agencies on the sharing of data on suicide and self harm (such as between Northumbria Police and NTW) and between those agencies for the support of vulnerable ex-offenders within the community. This should include explicit reference to the sharing of information with 3rd sector organisations**
8. Work with HM Coroners to ensure key professionals, especially GPs, are informed of the death of their patients in a timely manner

Commissioning

9. Influence NHS/Local Authority commissioning concerning the delivery of suicide prevention initiatives and resource identification
10. Assess the efficacy of established needs assessments/Joint Strategic Needs Assessments in relation to suicide prevention

Governance arrangements

- 11. Develop co-terminous Terms of Reference across the existing sub-regional Suicide Prevention Task Forces**
12. Provide quarterly updates to Task Forces and seek quarterly updates from those groups
13. Develop a communications plan which will include how task groups communicate with one another
14. Issue recommendations on the development of suicide prevention initiatives to Local Strategic Partnerships, Government Office for the North East and Directors of Public Health, amongst others

Training

- 15. Develop a regional route for the implementation of findings from the Training Needs Analyses developed by Chester-le-Street MIND and the Safer Care Group on Suicide Prevention. This should include reference to the training needs of other agencies (*in partnership with Safer Care Suicide Group*)**

Management of Suicide Clusters

- 16. Develop a regional protocol for dealing with suicide clusters. This will involve testing a protocol developed in Northern Ireland within Northumberland, Tyne and Wear Foundation Trust and sharing the learning from the Easington Independent Review**

Serious Untoward Incidents

17. Facilitate the development of an SHA-wide (and multi-agency) standardised approach to Serious Untoward Incidents/Significant Event Audits (SEAs). *This should involve learning from the current NHS County Durham approach where a bespoke SEA form is being developed for cases of self harm and suicide.* This will ensure that outcomes from these reviews are embedded within Governance reporting routes.

INITIATIVES: DEVELOPMENTS

1. Contact with GP/Primary Care/Acute Care

- Develop and provide specialist training in suicide prevention and seek opportunities for cost-effective training programmes on the detection and management of depression
- Develop Local Enhanced Services Payments for a review of all suicides in primary care
- **Use Personal Medical Services (PMS) contracts (where they exist) to ensure that all GPs retain responsibility after non-crisis referrals to ensure co-ordination of care** and examine the feasibility of including a commitment to complete a Significant Event Audit in cases of death by suicide or undetermined injury
- Audit the use of existing, related guidance (for example, the Royal College of Psychiatrists/Physicians guidance on the psychological care of medical patients (2003) & NICE guidance on supportive/palliative care for adults with cancer (2004))
- Review of assessment tools for use within Primary Care, for example Beck's Depression Inventory, and copyrighting issues

2. Self Harm

- **SHA-led review to improve the coding of self-harm in acute care settings. This will include a review of the pathways between General Hospitals/Emergency Care Departments and mental health services and procedures for follow-up post-discharge (*in partnership with Safer Care Suicide Group*)**
- As part of the planned 2010 Care Quality Commission (CQC) review into the standard of physical healthcare for people with mental health problems there will be review of the number of cases receiving an assessment of suicide/self-harm risk in general hospitals. It will be imperative to learn the lessons from this work and support the implementation of any recommendations
- Pilot the Scottish model of issuing 'Green Cards' to people self-harming who present to Emergency Care Departments
- Evaluate and share learning from (within County Durham and Darlington): use of *Sad Person's Scale* in custody suites prior to referral to Criminal Justice nurses, use of *Better Services Collaborative* self harm leaflets in custody suites and HMS Holme House care plan template following the release of prisoners

3. Suicide hotspots (including on the transport network)

- An annual review of suicide hotspots within the region and maintenance of existing signage
- Work with local rail providers to pilot Samaritans posters/training at selected stations
- Review the findings from the research into suicide hotspots in the North West (2009). In particular:
 - The mapping system: MapInfo Professional;
 - Extending the work of their Public Health Observatory in relation to suicide audit to include fields on hotspot analysis.

4. Prescribing

- Review suicide audit toolkits to assess the viability of including a field on medications used in all suicides (whether primary cause of death or not) as occurs in TEWV
- **Primary Care Organisations/Mental Health Foundation Trusts to audit the prescribing of Tricyclic Antidepressants including spend and duration**
- **Primary Care Organisations to report changes to amitriptyline prescribing (as well as dosulepin) including its use for pain management**
- **Primary Care Organisations to audit the continued use of co-proxamol**
- **Prescribers to audit adherence to recently published NICE guidance on depression and National Collaborating Centre for Mental Health guidance on depression in adults with chronic physical health problems.** They should take into account toxicity in overdose when choosing an antidepressant for patients at significant risk of suicide. They should be aware that:
 - Compared with other equally effective antidepressants recommended for routine use in primary care, venlafaxine is associated with a greater risk of death from overdose;
 - Dosulepin should not be prescribed for adults with depression & chronic physical health problem
 - Tricyclic Antidepressants, except for lofepramine, are associated with the greatest risk in overdose;
 - Service users with depression who have been started on amitriptyline or dosulepin, and who have been assessed as a suicide risk and/or are under 30 years of age, are seen after 1 week and frequently thereafter
- **Regional Suicide Prevention Steering Group to write to all GPs, nurse prescribers and consultants in acute health and mental health services outlining current evidence on medications used in suicide**

- **Waste management strategies to be developed at Community Pharmacy/General Practice level**
 - Pharmacies to be provided with contact numbers for helplines/ community mental health teams
5. Lesbian, Gay and Bisexual issues (with a separate focus on Transgender issues)
- Establish a baseline suicide rate for people undergoing gender transition
 - Extend the coverage of *Stonewall LGBT Diversity Champions* and *Workplace Equality Index* across the region
 - Assess impact of *LGBT Inclusion Award* in Middlesbrough
 - Review the lessons learned from the Brighton & Hove Strategy (2008). In particular:
 - The need for multi-agency training for frontline staff (especially staff in health and social care) to challenge discriminatory practice which pathologises LGBT (for example the link often made between childhood sexual abuse and mental health);
 - The development of a flexible referral system;
 - Develop routine data collection systems in order to monitor the number of LGBT accessing services (in particular, the number referred from GP practices and via Emergency Care departments to mental health services);
 - Work with schools to develop policies to tackle homophobic bullying & encourage disclosure.
6. Working with the media
- Work with HM Coroners to monitor the number of suicides and unexpected deaths where charcoal burning and/or deaths by helium inhalation are the primary causes of death. In turn, work with the media to prevent the reporting of these methods
 - Develop and provide mental health awareness/suicide prevention training for media students and senior journalists
 - Increase the number of positive, mental health related news stories with service user input
7. Police, Prisons, Probation (including Approved Premises) & Youth Justice
- **Development, implementation and audit of 'gold standard' pathways across Criminal Justice agencies**
 - Assessment of the effectiveness of a Neighbourhood Policing project in Warrington in relation to social inclusive outcomes and reduced suicide rates
 - Understand the issues that are specific to offenders including high incidence of self harm whilst in custody, especially amongst women
 - Develop information sharing protocols especially for those vulnerable prisoners who will be released without licence

- Better understand the factors that heighten the risk of self harm and suicide amongst the offender population and develop methods for counteracting these
- Develop greater awareness of support and treatment opportunities and embed these into action plans
- Train appropriate Criminal Justice staff to better recognise indicators of suicidal tendencies (including roll-out of Mental Health First Aid)
- National Offender Management Service (NOMS) to seek to strengthen the offender care pathways that exist between prisons and probation, including information sharing protocols and closer inter-agency working arrangements
- HM Prison Service to develop the NE Prisons' Suicide Prevention Forum into a model of good practice thus ensuring consistency of delivery and shared learning across the region. As a priority during 2010/11, the forum will:
 - Develop a regional camera cell protocol;
 - Develop a regional safer cell protocol;
 - Carry out a health check in all NE prisons against the thematic review into recent deaths in custody at HMP Durham and make changes/adjustments to practice where appropriate;
 - Share learning from Prisons and Probation Ombudsman reports and the findings of Inquests, and monitor the implementation of action plans which arise from these;
 - Develop the Region's relationship with NOMS Safer Custody and Offender Policy Group, to ensure that Safer Custody policy is implemented effectively in all NE prisons.
- Develop the role of the NE Safer Custody 'Champion' who will take forward the Safer Custody agenda for NE prisons in his/her capacity as chair of the Prisons Regional Forum
- Secure prison representation at the Regional Suicide Prevention Steering Group, the NE Safer Care Group, and the three Suicide Prevention Taskforces in Northumbria, Durham and Teesside. The expected outcome of attendance at these meetings will be to ensure improved multi-agency working and links into other relevant partnerships that have an influence on offender care pathways
- Share learning from the HMP Low Newton *Primrose Project* regarding its work with female offenders who pose a risk of serious harm because of a severe personality disorder
- Share learning from the Commissioners/NOMS/University of Durham project on women who self harm in Low Newton
- Share learning from the co-commissioning model on CARATs (Counselling, Assessment, Referral, Advice and Throughcare for those with a Substance Misuse problem) in relation to interlocked service specifications from transfer to secure settings to the community

8. Other Priorities

- Evaluate the effectiveness of the County Durham and Darlington Bereavement Support Service
- Work with the Safer Care Suicide Theme Group to implement the 'Preventing Suicide' toolkit for Mental Health Services and Prison Healthcare Units
- Promote use of the NHS Stressline (0300 123 2000) amongst the general population (helpline deals with issues relating to debt, housing and employment and poses a question on suicidal ideation)
- Evaluate and share learning from the NTW Foundation Trust clinical audit on the impact of Traumatic Brain Injury on mental health
- Suicide Prevention for service people and veterans
- Men: promote engagement with services and how services encourage men to access those services
- Collate data on self-harm/suicide in relation to refugees, asylum seekers, migrant workers and international students. HM Coroners to record asylum seeker status, ethnicity and country of origin
- Substance Misuse (including alcohol, illicit drugs and tobacco)

MEASURES: PROCESSES

1. Reduced suicide rates and Years of Life Lost as a consequence of suicide
2. Reduced suicide rates in high risk localities and within high risk groups and quantification of the economic cost of suicide
3. Reliable dataflow systems:
 - From and to HM Coroners
 - Suicide audit data at national, regional and local level
 - Self Harm data at regional, national and local level
 - Data on suicide shared between agencies in timely manner, including 3rd sector organisations
4. Mainstreamed suicide prevention within needs assessments and local and regional strategies
5. Free flowing information to and from the Regional Suicide Prevention Steering Group and sub-regional Suicide Prevention Task Forces/Groups
6. Regional protocol for management of suicide clusters which can be actioned following the identification of a suspected cluster
7. A standardised process for the operation of Serious Untoward Incidents and Significant Event Audits with lessons learned mainstreamed into service planning and development (and shared/involved other agencies)
8. A regional training plan on suicide prevention. The plan will include provision for the detection and management of depression in primary and acute care,

training on suicide prevention for criminal justice agencies, multi-agency training on LGBT issues to frontline staff and training on mental health awareness/suicide prevention to media students and senior journalists (as outlined in the section on 'Initiatives: Priorities')

MEASURES: DEVELOPMENTS

1. PMS contracts reflect the ongoing management of suicide prevention
2. Standardised approach to the coding of Self Harm across the region including increased numbers referred to Liaison Psychiatry and increased numbers followed-up post-discharge
3. Number of Samaritans' posters in train stations and Samaritans' training sessions to station staff
4. Regional approach to mapping suicide hotspots and medications present in verdicts of suicide and unexpected death
5. Reduced prescribing of older Tricyclic medication (especially amitriptyline and dosulepin), venlafaxine and no continued prescribing of co-proxamol
6. All pharmacies to receive contact/helpline numbers from local Community Mental Health Teams and Third Sector organisations
7. Increased number of schemes to promote return of unused medication
8. Increased monitoring of LGBT groups and an audit of school policies on homophobia
9. NO media reports on the use of charcoal burning as a method of suicide
10. Increased number of positive, mental health-related news stories with service user input
11. Gold standard pathways in place across Criminal Justice agencies
12. Regional protocols developed in relation to safer cells and camera cells
13. All prisons to have undertaken a health check following the review of deaths in HMP Durham
14. Routine sharing of lessons from Prisons and Probation Ombudsman reports and findings from Inquests into suicide within prisons
15. Bereavement support across region
16. MH Foundation Trusts to use the Preventing Suicide Toolkit as a matter of routine

Appendix 2: Terms of Reference for Regional Suicide Prevention Steering Group

REGIONAL SUICIDE PREVENTION STEERING GROUP TERMS OF REFERENCE – FINAL VERSION (For review October 2010)

The Regional Suicide Prevention Steering Group brings together key stakeholders in the North East Region to develop and deliver a regional suicide prevention strategy

In delivering this function, the key tasks of the Steering Group will be to:

- Develop a regional suicide prevention strategy which adds value to existing sub-regional arrangements and supports the delivery of suicide prevention initiatives at a local level.
- Support delivery of the content of the regional suicide prevention strategy ensuring that the objectives of the strategy correspond to planned and existing strategies and policies, for example *Better Health, Fairer Health, Our Vision, Our Future, Safer Care North East* and Local Area and Multi-Area Agreements
- Ensure that 'high risk' localities are identified and receive special focus in all Task Force activities. This should include working with HM Coroners to ensure the timely release of data on possible suicides
- Influence the NHS and Local Authority commissioning of services for people in relation to suicide prevention in the North East that will deliver the strategy and identify resources
- Identify and assess the rigour of established needs assessment procedures and support processes (including Joint Strategic Needs Assessments)
- Make recommendations on the development of suicide prevention services and advise on the prioritisation of such developments to the Local Strategic Partnership Boards as well as to Government Office for the North East and Directors of Public Health
- Draw on the experience and expertise of existing sub-regional suicide prevention task groups and other national and regional policy streams to inform and influence the suicide prevention agenda in the North East

This will entail reviewing the Terms of Reference and reporting mechanisms of existing task groups with a view to standardising reporting arrangements and adopting a common language

- Using a standardised template, provide a quarterly update to task groups on progress against the regional strategy and seek quarterly updates from task groups on current activity
- Review how Task Groups and Suicide Audit Groups collect data in relation to suicide and unexpected death, work with the North East Public Health Observatory (NEPHO) to collate and analyse data at a regional level and ensure that there are robust reporting arrangements in place to share data with the National Confidential Inquiry into Homicide and Suicide
- Encourage an SHA-led standardised approach to the management and operation of Serious Untoward Incidents/Significant Event Audits across the region. This should include the provision of guidance on types of unexpected death (including expected suicide) and the development of a common system for ensuring that findings become part of Governance structures (including reporting routes). This should also include establishing routes of communication with HM Coroners to ensure that key professionals (especially GPs) are informed of the death of their patient(s) so that they can begin the review process
- Develop a cross-service communications plan which will include a requirement for Task Groups to share information with one another and provide guidance on managing a sudden increase in cases

In addition, the Chair of the Steering Group will:

- Ensure a strategic fit between the objectives of the steering group and existing regional strategy and policy
- Ensure that organisational representatives are aware of their responsibilities regarding communication within their own organisation and networks and the benefit of building these Terms of Reference into their organisational Governance systems
- Allocate responsibilities to each member of the steering group
- Co-opt representatives from other organisations/agencies/groups, on invitation.

Members of the Steering Group will:

- Represent agencies likely to have the greatest impact on reducing the suicide rate within the North East
- Ensure that, when identified, work is actioned
- Report back to their existing networks (geographical and/or sectoral) about progress of the steering group

- Whilst representing and contributing on behalf of their organisation, operate as independent advisers and commit to working towards the maximisation of benefits for the region as a whole

Accountability

The Steering Group will report to the Chief Executive Officer (CEO) Mental Health & Learning Disability Commissioning Group and Joint Investment Partnership (JIP). It will also seek to establish connections with other stakeholder groups impacting on suicide prevention. Pages 4 and 5 provide more detail in contrasting the current structure with the suggested one.

As the work of the Safer Care NE Suicide Clinical Group will have a bearing on the work of the steering group, it is expected that meetings of both groups will take place on the same day.

Meeting Arrangements

The group will meet quarterly

Membership

The membership of the Regional Suicide Prevention Steering Group comprises members drawn from across key agencies within the region. Membership will include the following:

- Chair (Regional MH/LD Commissioning Team – Brian Key)
- Vice-Chair (NEHMDU – Neil Johnson)
- Safer Care NE (Delcy Wells to deputise Emma Marsden)
- Public Health representation (Sue Milner)
- Mental Health North East (Lyn Boyd)
- Service user/carer lead (Alisdair Cameron to identify)
- Child Health representative (Mick McCracken)
- Older Person's representative (NEMHDU – Steve Amos)
- Sub-regional Suicide Prevention Task Forces/Groups x3 (Tony Gray, Andrew Russell, Denise Colmer/Keith Linsley)
- Police (Superintendent Barbara Franklin)
- Probation (Keith Norman)
- Prisons (Clair Hutchings-Budd)
- ADASS (Neil Revely to identify)
- NHS Direct (Dave Cutler)

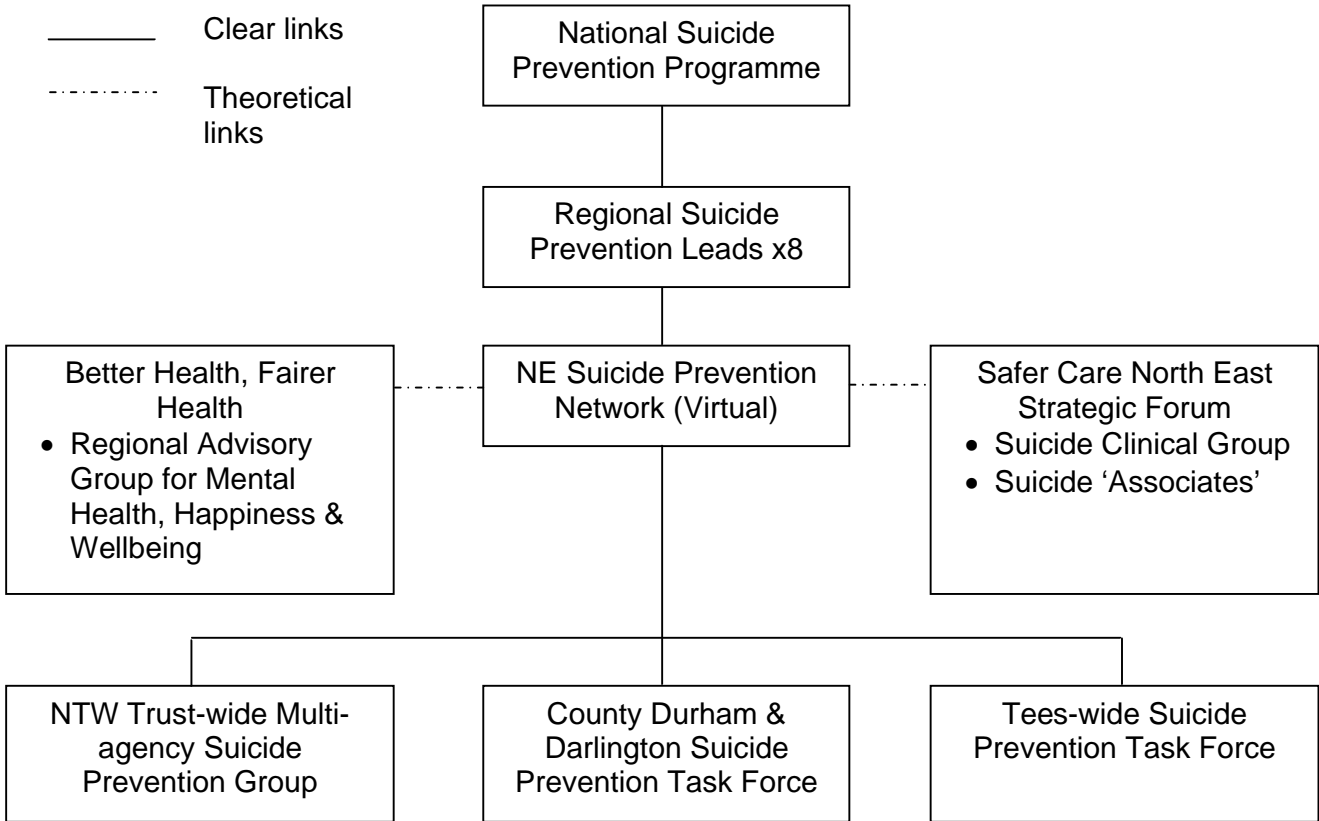
Co-opted members

In addition to the core membership outlined above, the following organisations/people will attend meetings on invitation.

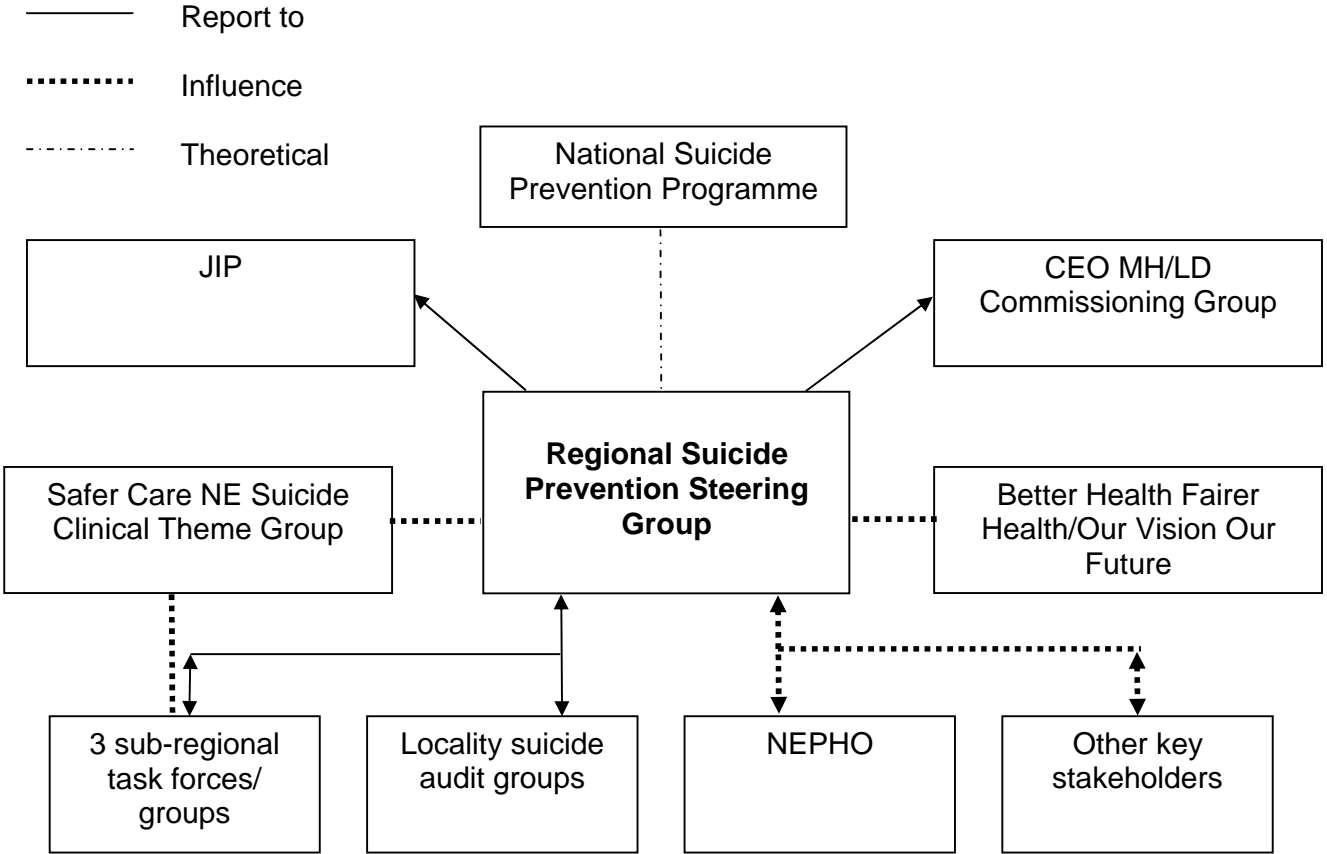
- Representation from Maternity Services
- Communications lead re: working with the media

- Migrant Health agenda (Alan Brice – Medical Foundation)
- Regional Pharmaceutical Committee/Heads of Medicines Management
- General Practice/Health Visiting
- Acute Care (Building Bridges – Alan Foster OR via Delcy Wells)
- Network Rail

Regional Suicide Prevention Strategy: Current Structure



Regional Suicide Prevention Strategy: Suggested Structure



Appendix 3: Action Plan from Safer Care Group on Suicide Prevention

OBJECTIVE

To reduce the number of suicides and unexpected deaths in people who are receiving secondary mental health services in the North East.

GOALS

- 1. *To support local provider and commissioning organisations, and Suicide Prevention Groups in the Region, in targeted local work on suicide prevention in people who are in receipt of secondary mental health services.***
- 2. *To improve the safety of care and treatment of people who are receiving secondary mental health services.***

INITIATIVES

1. Agree and confirm the Terms of Reference of the Safer Care Group on Suicide Prevention and the Regional Suicide Prevention Strategy Steering Group, setting out in each details of cross membership, communication and reporting arrangements and showing how joint or linked objectives will be agreed and delivered. Similarly agree and confirm cross membership, communications and reporting arrangements with the Mental Health Clinical Innovation Team.
2. Support the Regional Suicide Prevention Strategy Steering Group as required in developing the Regional Strategy; specifically, scope existing education and training modules for staff in relation to suicide prevention, identify which modules are the most effective, and develop an education and training strategy which will form part of the wider strategy.
3. Support improvements in communications and risk assessment by:
 - a. Determining the potential benefits for managing and reducing risk in the use of the SBARD (Situation, Background, Assessment, Recommendation, Decision) structured communications and handover system, following the current pilot at Tees, Esk and Wear Valleys NHS FT.
 - b. Reviewing the functionality, coverage, usage and training for staff in relation to the IT systems operating currently in the two mental health Trusts, and optimizing multi-disciplinary communications about patients, their treatment and current risk assessment using these systems.

- c. Agreeing the elements of a Gold Standard IT system which would overcome the limitations of existing systems and optimise multi-disciplinary communications within each Trust, across Trusts (including acute Trusts and the Ambulance Trust) and with primary care and NHS Direct, and establishing effective working links with IM&T planning across the Region to ensure that these elements are understood, discussed and included in future strategic IM&T plans.
4. Review the current audit programmes in both mental health Trusts, identify potential gaps in the programmes and agree how these will be addressed by the Trusts; identify lessons emerging from the audits that are relevant to suicide prevention, monitor implementation of actions agreed, and note in future audits whether improvements have been effective and should be adopted more widely.
5. Develop a Global Trigger Tool for mental health drawing on the current national pilot in which Tees, Esk and Wear Valleys NHS FT is participating.
6. Develop a plan for the local delivery of training in situational awareness and Human Factors to crisis teams and other relevant staff; and determine whether a Train the Trainer approach would be effective. Northumberland, Tyne and Wear NHS Trust have agreed to have all their crisis teams trained in the next two years.
7. Review the safety culture audit tools available and develop a plan to audit safety culture; include in this an audit of clinician attitudes to the inevitability of suicide.
8. Review the impact of training in risk assessment in terms of the confidence achieved by staff who undertake this training in taking forward actions to mitigate risk.

MEASURES

1. Terms of Reference for Safer Care Group and Regional Suicide Prevention Strategy Steering Group, showing working relationship between the two Groups (structural measure).
2. Education and training for suicide prevention reviewed by the end of March 2010 (process measure).
3. Qualitative evaluation of SBARD tool (process measure).
4. Action plan to optimise use of existing IT systems (process measure).
5. Effective links with IM&T strategic planning (structural measure).
6. Qualitative evaluation of Trust audit programmes (process measure).

7. Qualitative evaluation of Global Trigger Tool (process measure).
8. Plan for roll out of training in Human Factors (process measure).
9. Audit tool to assess safety culture, and in due course, results of audit (process and outcome measures).
10. Qualitative evaluation of risk assessment training (process measure).
11. Ongoing monitoring of Serious Untoward Incidents (SUIs) and National Reporting and Learning System (NRLS) data relating to suicide and unexpected death, and qualitative data on root causes and lessons learned (impact and process measures).
12. Annual audit of patient and carer satisfaction carried out by the Care Quality Commission (impact measure).
13. Death rates by suicide from 1995/96/97 (3 year rolling data – outcome measure).