Surrey Suicide Prevention

Strategy 2019-2021

Surrey
Suicide
Prevention
Partnership

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Forward

Around 13 people die by suicide every day in England (Department of Health, 2017). In Surrey there are on average 92 deaths by suicide each year. When someone dies by suicide, the effect on their family, friends and community is devastating. If we want to improve the life chances of future and current generations, we need to address this tragic reality and do more to prevent suicides.

The suicide rate for Surrey is lower than England and the South East region. Since 2008 real progress has been made in Surrey to reduce the suicide rate. But there is no room for complacency. There are new challenges that need to be addressed including the rising rates of self-harm in children and young people, the influence of social media on mental health and wellbeing, and economic changes.

The factors leading to someone taking their own life are complex. No one organisation is able to directly influence them all. Therefore commitment across statutory services, voluntary sector, academic institutions and schools, businesses, industry, journalists and other media is vital. Most importantly this commitment must involve communities and individuals whose lives have been affected by the suicide of a family member, friend, neighbour or colleague.

In developing this multi-agency suicide prevention strategy for Surrey, we have built on the successes of the earlier suicide prevention plan 2014-7. This strategy draws on local and national intelligence and evidence. The strategy is organised under six key priorities that reflect the national Suicide Prevention Strategy (2012). There are actions for each of the priorities to be delivered by the Surrey Suicide Prevention Partnership and Surrey and Borders Partnership Trust (as the lead provider for secondary mental health services). It includes recommendations for key partner organisations in the wider health and care and voluntary sector system, recognising their important role in the delivery of the strategy.

‘Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives (Department of Health, 2017)’ acknowledges that suicide is preventable. The subsequent appointment of a Suicide Prevention Minister in October 2018 by the Prime Minister, and the publishing of the first Cross-Government Suicide Prevention Workplan in January 2019 (Department of Health and Social Care , 2019) demonstrates there is a greater national momentum to support our work on a local level in Surrey to help prevent the tragedy of suicide taking peoples’ lives.

We would like to thank everyone involved in the development of this strategy for their continued support to implement its actions and recommendations, which is central to our efforts to prevent suicides in Surrey. We include a special thanks to everyone who participated in the consultation on this strategy. We have listened and included your feedback in the final strategy.

Encouragingly, the latest suicide figures for 2015-17 show that there has been a small decrease in the suicide rate in England and for Surrey. It is crucial that we build on this momentum and work together to continue to reduce the suicide rate in Surrey.

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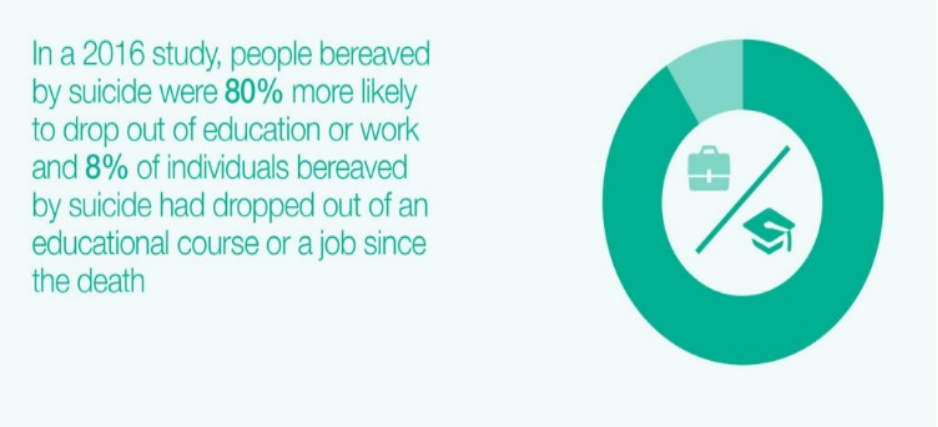
1. Introduction

Around 13 people complete suicide every day in England (Department of Health, 2017), with each and every suicide sending shockwaves through families and communities. Suicide is the leading cause of death for men under 50 and for young people (Department of Health, 2017). Each suicide has far reaching consequences, affecting a number of people directly and many others indirectly, with those affected often impacted economically, psychologically and spiritually (HM Govt, 2012).

Family, friends and carers of those who die by suicide have a 1 in 10 risk of making a suicide attempt after experiencing loss. Thus, suicides lead to the worsening and perpetuating cycle of inequalities (Mersey Care NHS Foundation Trust, 2016).



It is estimated that nationally, around one third of those who die by suicide in England have been in contact with mental health services in the 12 months leading up to their death, a further third have seen their GP but are not receiving specialist mental health support (Department of Health, 2017).

Self-harm (including attempted suicide) is the single biggest indicator of suicide risk and approximately 50 per cent of people who have died by suicide have a history of self-harm (Department of Health, 2017).

Suicide is often the end point of a complex history of risk factors and distressing events. The prevention of suicide has to address this complexity. As there is no single risk factor for suicide, the prevention of suicide does not sit with any single organisation. Rather, healthcare services, local government, public health bodies, third sector organisations and the communities in which individuals reside **all** have a role to play in the prevention of suicide (HM Govt, 2012). In many cases, suicide is an avoidable death, preventable by identification of risk, public health interventions and high quality evidence-based care. A robust suicide prevention approach needs to take place at individual and population levels and so needs the input of front line services, commissioners and policy makers.

Therefore the Surrey Suicide Prevention Partnership is a multi-agency collaboration between health, local government, people with lived experience and the voluntary sector. This strategy sets out our approach to reducing suicide in Surrey, based on national and local intelligence/evidence. It also reflects the national suicide prevention strategy ambition and key action areas.

The national suicide prevention strategy for England sets out key areas of evidence-based action for local areas (HM Govt, 2012). Through the NHS Five Year Forward View for Mental Health, the Government renewed their commitment to **reducing suicide nationally by 10% by 2020** (NHS England, 2017). In January 2018 the Secretary of State announced a zero suicide ambition for mental health inpatients. In January 2019, the first Cross-Government Suicide Prevention Workplan (HM Government, 2019) was published with a focus on social media, self-harm and how technology such as predictive analytics can identify those most at risk.

2. A Strategy for Suicide Prevention in Surrey

A reduction in the death rate from suicide is a priority of Surrey's Joint Health and Wellbeing Strategy, signalling the commitment of partners across the NHS and Local Government to work together to save lives lost to suicide, through both whole population and targeted actions. This strategy will harness that commitment to achieve the following aim:

> **To reduce suicide by 10% by 2021 through the coordinated actions of our respective organisations**.

This strategy will sit alongside the Emotional Wellbeing Mental Health Strategy for Children and Young People in Surrey 2019-22.

Our ethos in Surrey is that every single suicide is a tragedy and is one too many. Our ultimate aspiration is, therefore, to eliminate suicide. We recognise the complexity of the factors that lead to someone taking their own life and although we may not be able to prevent every suicide, we will make zero suicides in Surrey our ambition. We believe this will facilitate a transformation of attitudes toward suicide locally, making it clear that suicide is not inevitable and that our organisations are jointly committed to the prevention of suicide locally.

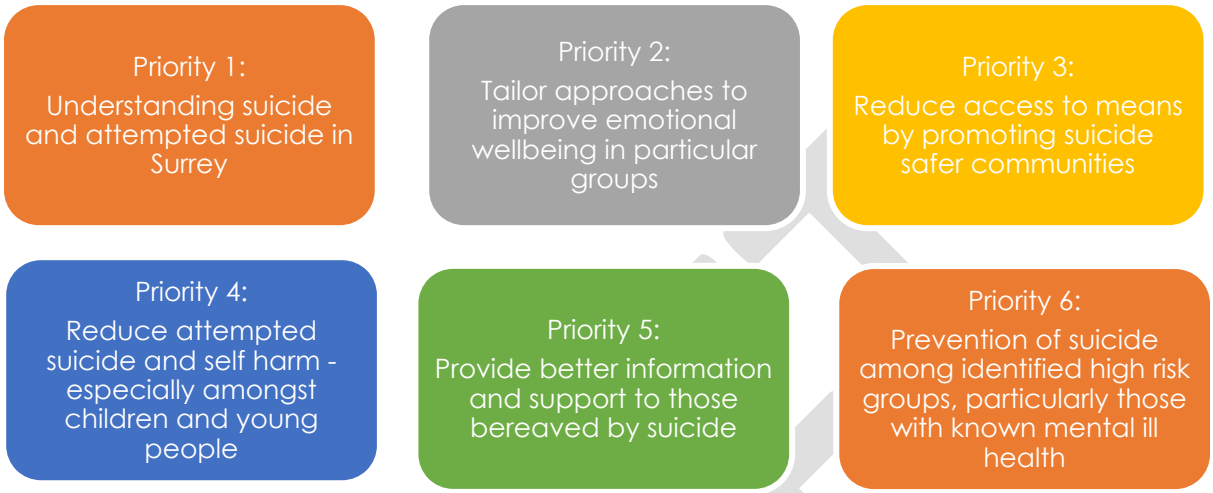
The protective factors for suicide are complex and broad and therefore achieving the ambition for a reduction in suicide requires action across a number of fronts as shown by Figure 1.

Figure 1: A comprehensive approach to Suicide Prevention in Surrey

Action across the Wider Determinants of Health	• Connectedness • Economic support • Meaningful employment	• Adequate housing • School readiness
Universal Mental Health and Wellbeing approaches	• Building Resilience • Anti-Stigma campaigns	• Access to wellbeing self-help resources • Mental Health awareness
Health Services (Primary Care, ICPs, Public Health Commissioned services)	• Identification and signposting	• Substance Misuse Treatment • Primary and secondary support and pathways
Surrey Suicide Prevention Strategy Actions	• Understanding suicide and attempted suicide in Surrey • Reduce access to means • Tailor approaches to improve emotional wellbeing in particular groups	• Prevention of suicide among identified high risk groups • Reduce attempted suicide amongst children and young people • Provide better information and support to those bereaved by suicide
Mental Health Service Strategy	Effective acute and community Mental Health care and treatment	Mental Health Crisis - Safe Havens

This strategy draws on local and national intelligence and evidence and is organised under six key priorities, reflecting the national strategy (see figure 2). For each of the priorities we have set out actions for delivery by Surrey Suicide Prevention Partnership and Surrey and Borders Partnership NHS Foundation Trust Forum (see section 7). The strategy also makes recommendations for the wider health and care system and their important role in the delivery of this strategy.

Figure 2: Priorities of the Surrey Suicide Prevention Strategy



3. Suicide in Surrey

On average there are 92 deaths by suicide in Surrey each year, with six of these among the under 25s. This equates to eight people a month or 2% of all deaths among people under the age of 75 in Surrey. The suicide rate is calculated as a three-year average. In Surrey, the most up to date suicide figures available from Public Health England and Office on national Statistics are for 2015-17.

In Surrey, three suicide audits of Coroners notes were conducted between 2006-2013.

Interpreting differing numbers of suicides between localities in Surrey is more difficult due to the smaller numbers of incidents. Therefore comparison is more reliable through the use of suicide rates. At the time of writing the draft strategy, suicide rates for all CCGs were only available for period 2013- 2015, during which North West Surrey CCG had the highest rate of suicides (see Table 1). Since then 2015-2017 data has been published which shows that North East Hampshire and Farnham, then Surrey Downs CCGs had the highest rate.

Table 1: Suicide by CCG within a three-year period

CCG	Suicide rate (per 100,00) 2013 - 2015	Number of suicides 2013- 2015	Suicide rate (per 100,00) 2015-2017	Number of suicides 2015-2017
North West Surrey	11.1	100	7.4	68
Surrey Heath	9.9	25	8.9	23
East Surrey	8.5	41	8.3	40
North East Hampshire and Farnham	8.3	46	9.0	
Surrey Downs	8.2	63	8.6	64
Guildford and Waverley	7.6	42	7.9	43

(Source: Public Health England Fingertips Cited 2019)

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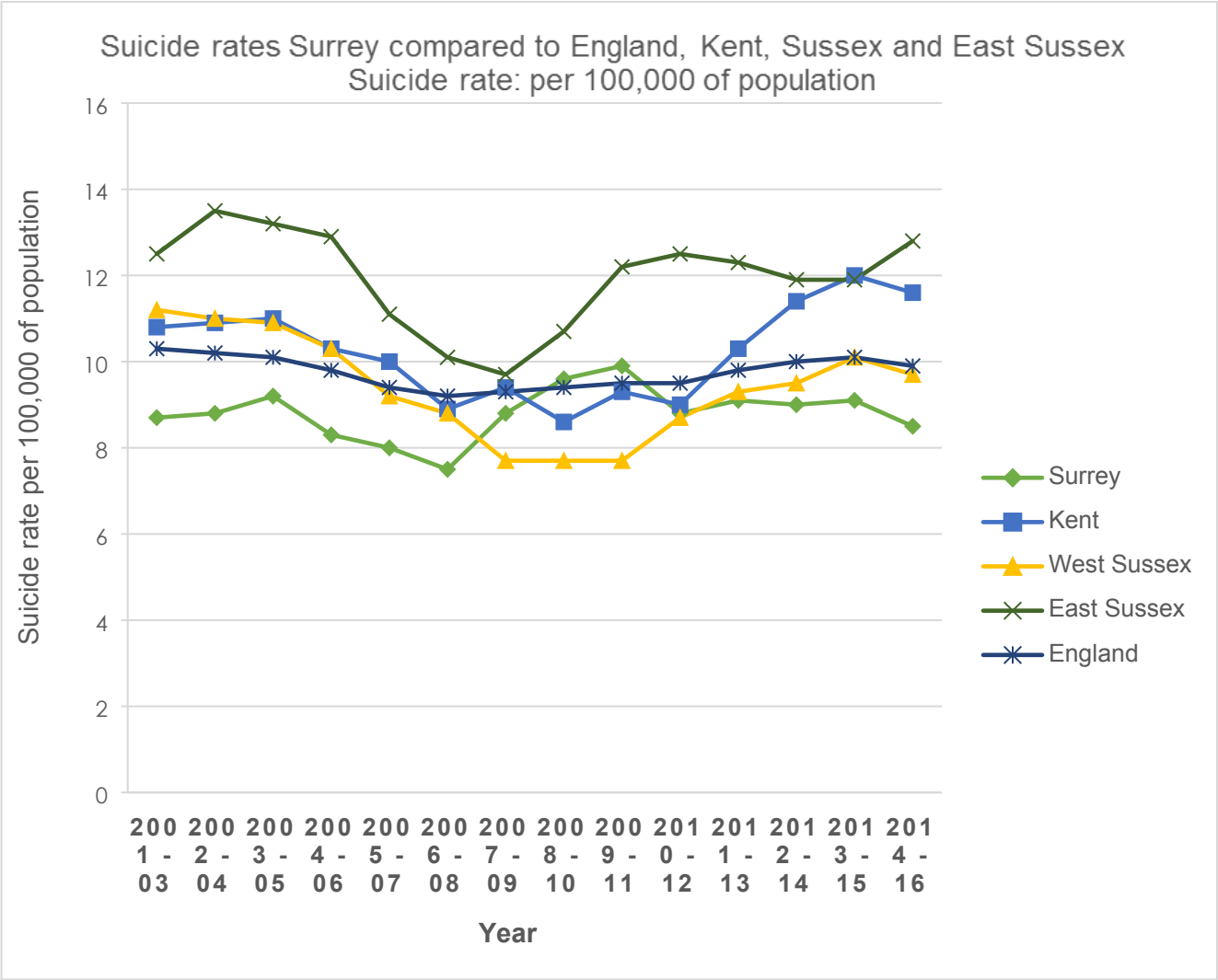
Figure 3: Suicide rates by Local Authority in Kent, Surrey and Sussex 2001-2016

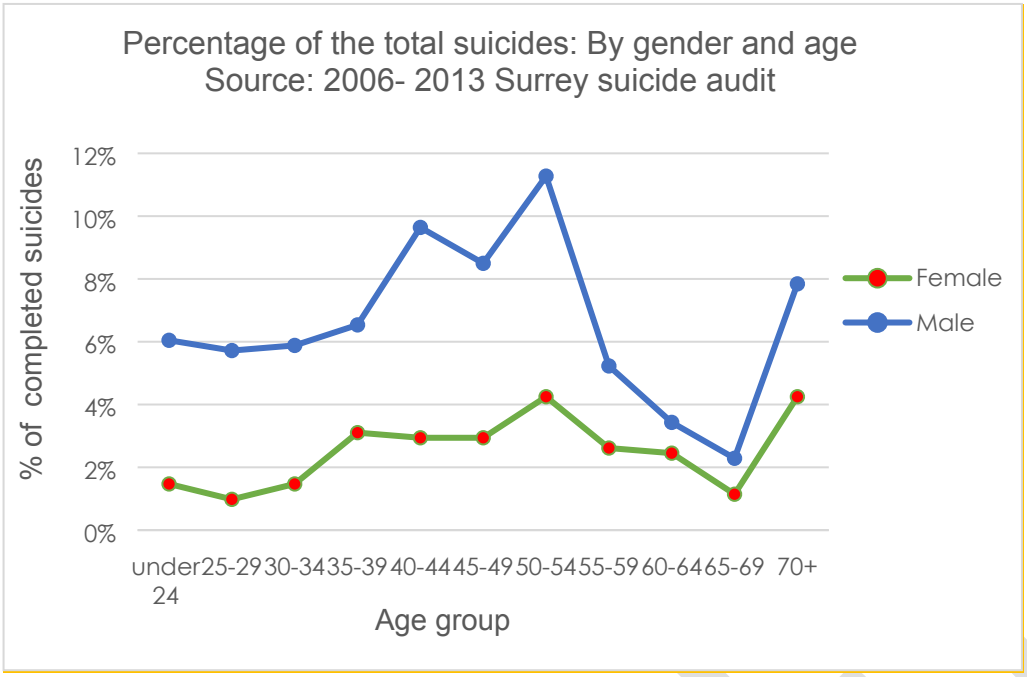


Source: Public Health England Fingertips

The suicide rates across England, Surrey and neighbouring Local Authorities has fluctuated over the last 10 years. In England there was a gradual increase in suicide rates during the financial crisis which began in 2007. This pattern can be seen more dramatically in Local Authority areas in the South East where the rate in Surrey increased from 7.5 in 2006-08 and reached 9.9 per 100,000 in 2009-11.

Latest figures show that in 2015-17 the Surrey suicide rate is 8.0 per 100,000 of the population, which is lower than both the rates for England (9.6 per 100,000 of the population) and the South East region (9.4 per 100,000 of the population) (Public Health England, 2019).

Figure 4: Suicide in Surrey by gender and age



Source: 2006- 2013 Surrey suicide audit

4. Surrey's high risk groups

Those who are the most vulnerable in our society are disproportionately at risk of suicide. Local and national intelligence has identified the following high risk groups and risk factors for suicide.

Men - particularly middle-aged men

Suicide remains the biggest killer in men under 50, they are three times more likely to die by suicide then women (Department of Health, 2017). Surrey's 2006-2013 suicide audits showed that 73% of those who completed suicide were male.

In Surrey of these male suicides the highest percentage was in middle-aged men.

- 6% were aged 18-34
- 12% were aged 25-34
- 17% were aged 35-44
- 19% were aged 45-54
- 8% were aged 55-64 (see figure 4).

It is recognised that for men, a significant barrier to talking about mental health problems is the stigma they feel about seeking help.

Older Adults

Surrey's 2006-2013 suicide audits showed a spike in suicides in older males and females aged 69+. Key factors for this included isolation, poor health and recent loss of a spouse.

Black Minority Ethnic Groups (BME)

In Surrey the number of suicide from Black Minority Ethnic groups is low. A number of factors for this include less suicide verdicts due to stigma and poor recording of ethnicity. People from BME groups are less likely to access support and treatment for mental ill health.

Surrey is less diverse than England as a whole with 83.5% of the population reporting their ethnic group as White British compared with 79.8% in England. More people in Surrey (6.9%) were recorded in other white ethnic groups (Irish, "Gypsy or Irish Traveler" and "Other White), than in England (5.7%) with fewer (9.6% compared with 14.6%) in all other ethnic groups. (Surrey County Council, 2018). The next largest ethnic group is Surrey was "Indian" (1.8% of the population) followed by Pakistani (1.0%). Only 0.2% of the Surrey population ticked the new Census box for Gypsy or Irish Traveler, however it is widely believed that the Gypsy, Roma and Traveler community is under reported in the Census.

Differences in ethnicity across local authorities and clinical commissioning groups:

- Woking is the most diverse local authority in Surrey with 16.4% of its population from non-white ethnic groups. Waverley is the least diverse with 90.6% White British.
- Elmbridge has the highest proportion (10.4%) in all other white groups ("Irish", "Gypsy or Irish Traveler" and "Other White") with Tandridge the lowest (4.6%)
- Spelthorne has the highest proportion of Indian ethnic group (4.2%) and Woking has the highest proportion of Pakistani ethnic group (5.7%).
- North West Surrey is the most diverse clinical commissioning group (CCG) with 12.5% of its population from non-white ethnic groups. Guildford & Waverley is the least diverse with 85.9% of its population White British.

Gypsy, Roma and Traveller Community

A national report by the Traveller and Roma Centre identified that traveller men have a 6.6 times higher suicide risk compared to settled men. The uptake of support services in the Traveller community is low despite the reported high rates of mental health problems (PAVEE Point, Traveller and Roma Centre, 2013). Some of the key factors for this are stigma of mental health in the traveller community, reluctance to discuss mental health and a mistrust of services.

People in the care of mental health services

Nationally around a third of those who die by suicide have been under the care of specialist mental health services within a year of their death. Surrey follows these trends – data from suicide audits show that 29% of cases were known to a secondary mental health service at some point in their life. In addition the Surrey suicide audits highlight that: 50% of cases had some form of mental illness mentioned in their notes (i.e. as a clinical diagnosis or as mentioned in their G.P notes); about a third (33%) had a clinical mental health diagnosis; nearly half (46%) suffered with depressive illness; and about one fifth (21%) had anxiety disorders.

A study by the University of Nottingham found that rates of attempted suicide or self-harm were highest in the first 28 days after starting a course of antidepressants (Coupland, 2015).

People in contact with the criminal justice system

Those who have been or who are involved with the criminal justice system commonly face multiple disadvantage including but not limited to: social exclusion, substance misuse, homelessness and mental and physical health problems.

Nationally there has been a sharp increase in deaths by suicide following police custody (Home Office, 2017), however this is not reported locally in Surrey.

Prisoners are at greater risk of poor mental health, self-harm and suicide. A report by the Ministry of Justice highlighted that the self-harm rate in prisons increased by 73% between 2012 and 2017 (MOJ, 2018).

An international study (Seena Fazel, 2017) reviewed suicide rates in prisons across 24 countries. The report calculated that the annual suicide rate for people in prison (sentenced and remand) in England and Wales is 83 per 100,000 of population. This is significantly higher than the general suicide rates in England and Wales.

In September 2018 there were 2,600 people in prisons across Surrey (Surreyi, 2018). Based on the prison suicide rate in the above report; each year there could be two suicides in prisons across Surrey.

Specific occupational groups

National data shows that specific occupations and those who are unemployed are at increased risk of suicide and self-harm (Dr Carlos Nordt, 2015). At risk occupations include doctors, nurses, veterinary workers, farmers and agricultural workers, low skilled occupations, low skilled male labourers and males working in skilled trades (ONS, 2017). This is usually correlated to increased access to means. However there are large national variations with these figures.

Blue light services

Surrey hosts large NHS employers including three Acute Hospitals (employing doctors and nurses) and other ‘blue light’ services including the Surrey Police, Surrey Fire and Rescue and South East Coast Ambulance service (SECAmb).

In 2016 Mind, a mental health awareness charity, carried out a survey to identify the mental health needs of staff and volunteers in police, fire, ambulance and search and rescue services. The survey found that blue light workers may be disproportionately at risk of suicide due to the nature of their jobs. Key findings from the survey include:

- One in four blue light workers had contemplated suicide due to stress and poor mental health.
- 92% of blue light workers had experienced stress, low mood and poor mental health at some point while working for the emergency services.

(MIND, 2016)

Farmers and agricultural workers

There is no data or information on the prevalence of mental health or suicide amongst farmers and agricultural workers in Surrey. However, the Farming Community highlights that nationally high levels of stress and depression exist in this group. (FCN, n.d.). A key reason for this is isolation due to long working hours and work related stress and pressures.

National data shows that suicide rates in farmers are among the highest in any occupational group and the risk of suicide is also higher amongst those working in specific agricultural roles

such as harvesting crops and rearing animals (ONS, 2017). This is also usually correlated to increased access to means.

Manual workers

The Office of National Statistics collects and reports suicide data by occupation. Data for 2011-2015 showed that:

- Males working in the lowest-skilled occupations have a 44% higher risk of suicide than the male national average.
- The risk of suicide among low-skilled male laborers, particularly those working in construction roles, was three times higher than the male national average.
- For males working in skilled trades, the highest risk was among building finishing trades – particularly plasterers and painters and decorators – who had more than double the risk of suicide than the male national average.

(ONS, 2017)

Serving armed forces

Data from the Ministry of Defence shows that since 1990, the UK regular armed forces have seen a decline in suicide rates and that the suicide rate amongst this group is significantly lower than the general population (MOD, 2018). However, in the strategy consultation professionals working with armed forces in Surrey report high levels of poor mental health and unrecognised mental health issues. Key factors for this include stigma, lack of awareness of mental health and a reluctance to talk about mental health.

Veterans

Nationally there is no actual data on the suicide rates amongst veterans. However, from the strategy consultation, health and social care professionals in Surrey reported high rates of post-traumatic stress, alcohol misuse, homelessness and poor mental health amongst Veterans.

Carers

Carers look after family, partners or friends in need of help because they are ill, frail or have a disability. The care they provide is unpaid. This includes: adults looking after other adults, parent carers looking after disabled children, and young carers under 18 years of age looking after siblings, parents or other relatives. Based on the 2011 Census and population projections we can estimate that in 2016 there were 115,216 carers of all ages living in Surrey in 2016, this equates to 10% of the population (Surrey).

Carers have an increased risk of suicide that is almost twice the national average (ONS, 2017).

Through the strategy consultation process it was identified that carers for people with mental health needs should be equipped with the knowledge, information and support to enable them to care for a person who has experienced suicidal thoughts, or has previously attempted suicide. Carers felt that it was important to ensure that there was consent to share information and that they were involved in care plans and informed of any concerns and changes.

Lesbian, Gay and Bisexual and Questioning (LGBTQ)

An evidence review of mental health amongst people who identify as Lesbian, Gay and Bisexual (LGB), identified that LGB youth in the UK experience high rates of poor mental health with one in two reporting self-harming at some point in their life and 44% reporting having thought about suicide (PHE, 2015).

The fear of rejection from family, peers and society among young people who identify as trans, at a time of their developing sense of self (sometimes in an emotionally unsupportive environment), can create a sense of "otherness". This can leave trans young people particularly vulnerable to depression and suicidal thoughts (Royal College of Nursing and PHE, 2015) One study in the UK found that 34.4% of trans adults had attempted suicide at least once and almost 14% of trans adults had attempted suicide more than twice (Whittle, 2007). This higher risk of suicide is related to experiences of discrimination, including stigma, transphobia and bullying.

The 2011 Census did not collect information on sexual orientation so there is little reliable data on the number of people in these groups in Surrey. The UK Government estimates that 6% of the population are lesbian, gay or bisexual. Applying this to mid-2015 population estimates for Surrey means that there may be 56,500 people aged 16+ and around 4,000 people aged 11 to 15 in Surrey who are lesbian, gay or bisexual.

The Integrated Household Survey (ONS, 2014) found lower percentages in response to a question on self-perceived sexual identity of adults in the UK, with: 1.1% of the population nationally reporting as gay or lesbian (1.5% of men and 0.7% of women), 0.5% reporting as bisexual (0.3% of men and 0.7% of women) and 0.3% reporting an "other" option. However, 5.3% of the sample refused to answer the question or answered "don't know" or no response was received.

Data from the Census shows 0.7% of Surrey residents aged 16+ living in a same sex couple (in a registered civil partnership or cohabiting) compared with 0.9% nationally.

At present, there is no official estimate of the trans population. A Home Office funded study (Gender Identity Research and Education 2018, n.d.) estimated the number of trans people in the UK to be between 300,000-500,000 – where trans was defined as "a large reservoir of transgender people who experience some degree of gender variance". Applying this estimate to the Surrey population would lead to an estimate of at least 7,000 trans people in Surrey. Source Surrey-i (Surrey County Council, 2018).

Those misusing drugs and alcohol

The last Surrey suicide audit (2012-13) showed that 32.6% of those who die by suicide had a history of alcohol misuse and 21% had a history of substance misuse.

However, only 5% were known to the substance misuse treatment services available in Surrey.

'Preventing Suicide in England HM Government 2017' identifies drug and/or alcohol use as major risk factors for both suicide and self-harm, and co-morbid mental health and substance misuse problems are prevalent. 80% of those in treatment for alcohol use conditions and

nearly 70% of people in drug treatment are thought to have co-existing mental health problems.

There is considerable concern about the rising rates of drug related deaths, in which suicide features considerably – 28 per cent of women's deaths and 11 per cent of men's deaths registered in 2014.

People with a history of self-harm

Self-harm, (with or without suicidal intent) is the biggest predictor of suicide. National figures report that 50% of those who have died by suicide have a history of self-harm. However the latest Adult Psychiatric Morbidity Survey for the UK (Sally McManus, 2014) shows that only about 28% of men and 43% of women surveyed received medical or psychiatric treatment after self-harming (Department of Health, 2017).

The last 2012-2013 Surrey suicide audit reported that 25% of cases had a history of self-harm mentioned in their notes.

Children and Young people, specifically those with adverse childhood experiences and those experiencing self-harm

1% of suicides in Surrey are among those who are under 25. Suicide in children and young people has a significant emotional and mental impact on other young people, families and the local community.

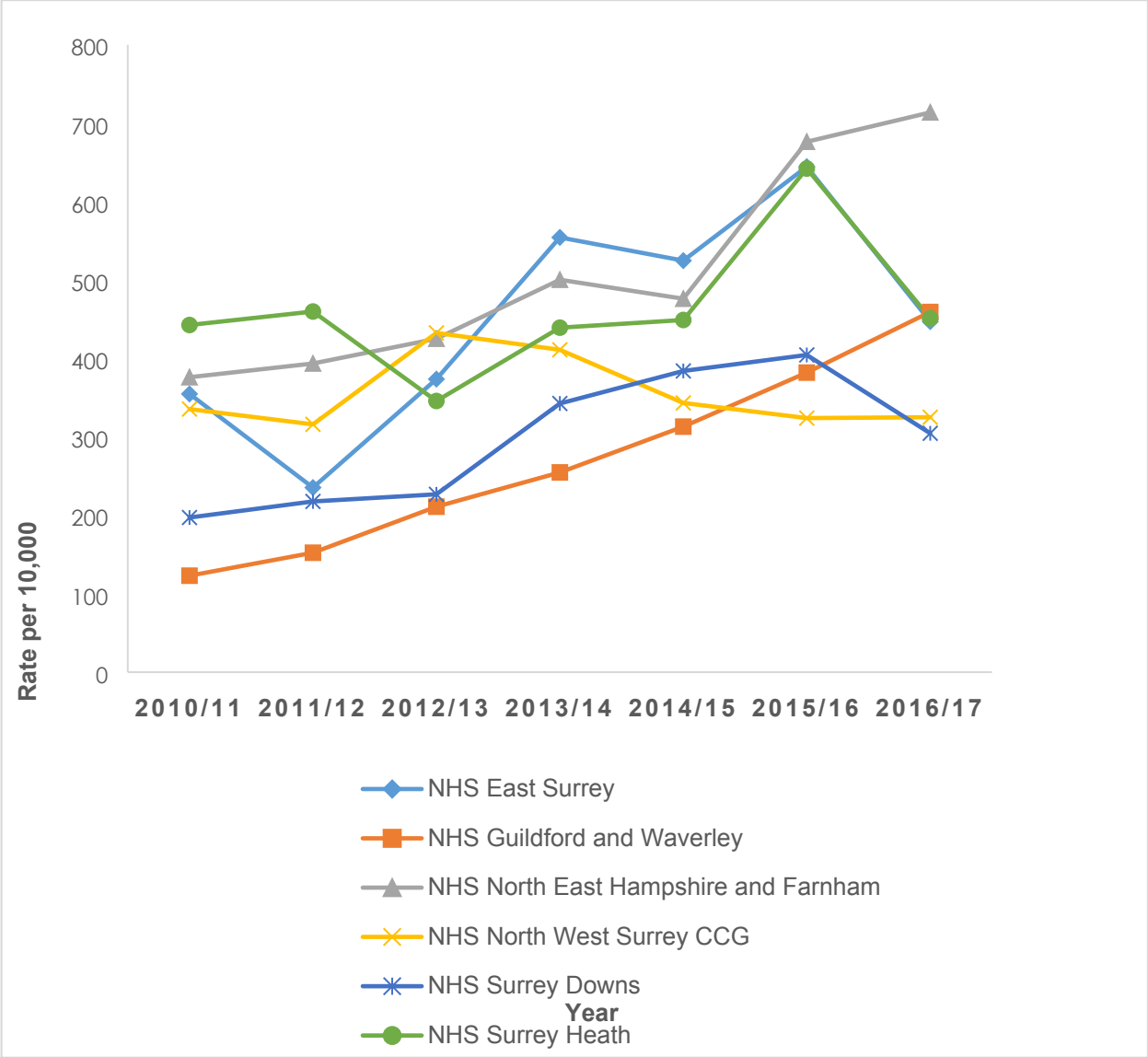
A report by Young Minds highlights that 1 in 3 adult mental health conditions is related to adverse childhood experiences (Young Minds, 2016). These experiences include neglect, abuse, poverty, parental alcohol or substance misuse, parental poor physical or mental health, and parental suicide. Adverse childhood experiences increase the risk of suicide (Devaney, Northern Ireland).

In Surrey, whilst we have access to data on self-harm resulting in a hospital attendance, not every incident of self-harm will require hospital treatment.

The rates of hospital admissions for self-harm per 10,000 population of 10-24 year olds in Surrey has increased over the last seven years. Data for 2015-16 showed that Surrey had a rate of 448.1 of the directly standardised rate per 100,000; compared to the national rate of 430.5 (but lower than the S.E. England rate of 469.4). (Surrey County Council, n.d.).

Most recent 2016-2017 data shows North East Hants and Farnham CCG has the highest rate of hospital admissions per 10,000 population as a result of self-harm (see Figure 5). The rate for North East Hants and Farnham is significantly worse and for Guildford and Waverley CCG is worse than their benchmark comparator areas in the sub region of South East England (PHE Fingertips, 2018). However the 2016/17 data showed a reduction in the rate for East Surrey, Surrey Heath and North West Surrey CCGs – see Figure 5 (PHE Fingertips, 2018).

Figure 5: Hospital admissions as a result of self-harm in 10-24 year olds 2010-2017 by CCG



Source: (PHE Fingertips, 2018)

Many children and young people who self-harm feel guilty and afraid. There is often a fear of being labelled as attention seeking. The stigma around self-harm stops young people accessing support (Mental Health Foundation, 2012).

Those with long term conditions

The last Surrey 2012-2013 suicide audit report showed that 25.5% of cases cited a general health related problem. This is nearly double the number within the previous 2009-2011 audit (12.4%). In addition 19.9% reported a chronic health condition. In an ageing population, more people are likely to experience poorer health.

Poor physical health, long term conditions and disability are risk factors for poor mental health. Having a long-term physical conditions such as diabetes, arthritis or asthma, increases the risk of depression and anxiety (PHE, 2018).

Those diagnosed with general or chronic health conditions are typically in contact with a number of health and social care services.

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People bereaved by suicide

The emotional, mental and social impact of suicide is difficult to measure. However suicide causes a ripple effect in families and communities and the impact of suicide lasts for many years (Public Health England, 2016).

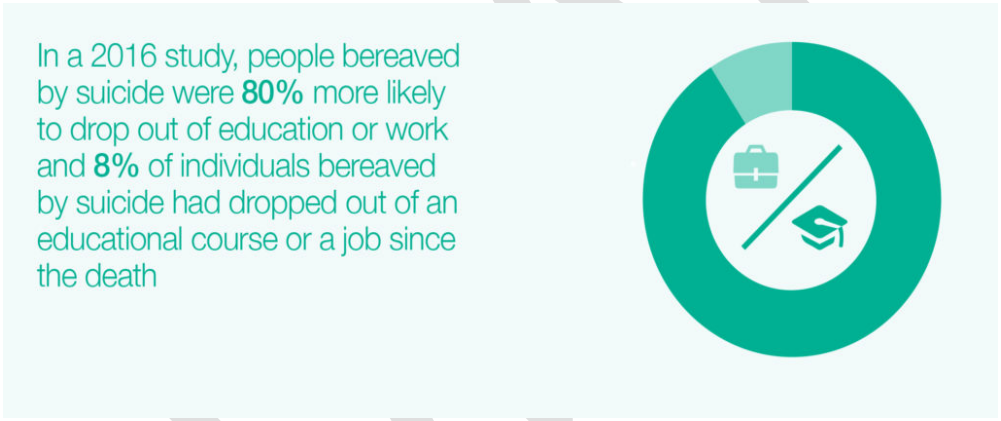
Each suicide is estimated to affect between six and 10 individuals. In Surrey on average 92 people a year die by suicide. Based on this data, on average:

- Each year between 552 and 920 people are directly affected by suicide bereavement.
- Each month between 46 and 77 people are directly affected by suicide bereavement.

A national cross-sectional study by the Psychiatry Division of University College, London found that adults bereaved by suicide, had a higher probability of attempting suicide than those bereaved by sudden natural causes (Pitman etal, 2016).

Additionally those who have been bereaved by suicide are most likely to experience:

- Poor mental health and social functioning.
- Financial difficulty.
- Loss of job.
- Loss of social networks.
- Breakdowns in family relationships.
- For those who had a caring role, a loss of caring responsibilities.



(National suicide prevention alliance, 2018)

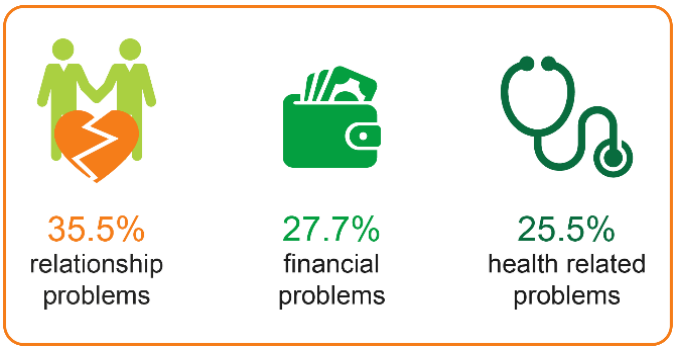
Other contributory factors

An underlying factor which will further place individuals at risk is inequalities. The report ‘Dying from Inequality’ identified the following factors in relation to inequalities (Samaritans, 2017):

- Areas of higher socioeconomic deprivation tend to have higher rates of suicide.
- The greater the level of deprivation experienced by an individual, the higher their risk of suicidal behaviour.
- Increases in suicide rates are linked to economic recessions.
- Men are more vulnerable to the adverse effects of economic recession, including suicide risk, than women.
- People who are unemployed are two to three times more likely to die by suicide than those in employment.
- The least skilled occupations (e.g. construction workers) have higher rates of suicide.
- A low level of educational attainment and no home ownership increase an individual’s risk of suicide.

Other contributory factors identified by the Surrey 2012- 2013 suicide audit include:

- Relationship problems.
- Financial problems.
- Health related problems.
- Poor sleep.
- Work-related stress.
- Increasing alcohol misuse with the year before death.



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5. Progress to date:

Prior to this strategy, there was the Surrey Suicide Prevention group (established in 2008). It produced the Surrey wide Suicide Prevention Plan 2014-17 based on evidence-based practice and local and national intelligence to identify priority areas for joint action. The case studies below highlight some of the successes delivered via this Suicide Prevention Plan 2014-17.

Case study 1: Working together to tackle high risk locations

A multi-agency group was established in 2017 in response to a number of suicides at Woking railway station/line, resulting in Woking being subject to the national rail escalation process. Members included: Woking Borough Council, British Transport Police, Surrey and Borders Partnership NHS Foundation Trust, Samaritans, NW Surrey Clinical Commissioning Group, Safe Haven and Community Connections. Some of the key actions included: community suicide prevention training, setting up a mental health champion scheme, improving awareness of local services and identifying ways to communicate information about individuals who maybe distressed.

Case study 2: Signposting

A directory of emergency contacts of local and national support services has been developed to signpost people to appropriate support. This is available on the Healthy Surrey website and has been widely distributed.

Case study 3 Safe Havens Adult

Safe Havens have been developed across Surrey and are delivered in partnership. They aim to provide accessible alternative care and support pathways for people in mental health crisis and their carers that focus on preventing crises before they happen. The development of Safe Havens is overseen by the Mental Health Crisis Care Concordat Delivery Group.

Case study 4: Those at risk who may present at A&E

There are a number of initiatives currently being embedded in collaboration with Surrey and Borders Partnership NHS Foundation Trust (SABP) including 'core 24'. Core 24 is a model of psychiatric liaison service. Surrey received some funding from NHS England to expand the provision of psychiatric liaison mental health services and provide specialist, compassionate assessment, detection and treatment of mental ill health in general acute hospitals. This is overseen by the Mental Health Crisis Care Concordat Delivery Group.

Case study 5: Training

The Surrey Suicide Prevention Group identified high risk groups and delivered targeted training to agencies working with these groups: GPs, Citizens Advice Bureau and Job Centres.

SABP also developed suicide prevention training for carers of people with mental health needs and professionals working in crisis care teams.

Between April 2015 and 31 March 2017, approximately 250 people from health, social care and third sector settings attended suicide prevention training.

Case study 6: Community Connections

Surrey Community Connections are universal access services that support people with mental health needs to stay well in their communities. They are an integral part of the pathway for people who experience mental health problems (and the frequent social isolation), often bridging the gap between primary mental health care and secondary mental health care.

The services promote independence and work in a person-centred way to enable people to achieve their desired outcomes. They also contribute to avoidance and management of crisis and a reduction in dependence on statutory services. There are three lead providers for different areas of Surrey (the Mary Frances Trust, the Welcome Project and Richmond Fellowship). They provide a range of one-to-one and group based mental health/wellbeing support and activities. Examples of some of the specific suicide prevention work done by Community Connections providers are listed below.

Richmond Fellowship
Richmond Fellowship provides a range of supported housing, community based and employment services for people with mental health problems across Surrey.

The Mary Frances Trust.
Examples of services and work delivered in Suicide Prevention include men's groups, Epsom Safe Haven, groups and courses.

The Mary Frances Trust run numerous courses, some of which are aimed at tackling issues which may lead to suicidal ideation. Examples include: Building Emotional Resilience, Stress Management, Self Confidence, Mood and Food.

The Welcome Project
If a referral has been identified as a suicide risk the person is contacted as soon as possible and offered an appointment. They are given advice and guidance to where they can go if they are feeling suicidal. Alerts on the database are implemented so workers can identify individuals at risk.

Case study 7: Citizen Advice Bureau (CAB)

CAB provide advice support and advocacy.

CAB has reported that the number of people presenting with suicidal ideations has increased over the last five years.

Some CAB staff and volunteers are trained in suicide prevention.

Case study 8: Diocese of Guildford

Mental health and suicide prevention has been embedded into the work of the Diocese of Guildford.

They offer information, resources and training sessions through the year covering subjects such as: suicide, self-harm, domestic abuse, drug abuse and addiction, health issues, mental health and eating disorders.

The Diocese of Guildford produce details of local food banks and other services to support people in a crisis.

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6. Delivering the priorities

Whilst there has been significant positive steps forward to reduce suicides in Surrey, there are some areas of best practice that have been challenging to implement. It has also been recognised that a single suicide prevention plan cannot capture the breadth of good work happening across Surrey to reduce suicide risk and harm. In some cases this can lead to areas of duplication or a lack of shared understanding and awareness.

This strategy aims to improve the coordination of our collective actions to maximise the opportunities to reduce suicide in Surrey. This section will, therefore, outline the current gaps where we can collectively make a difference in Surrey. For each priority we set out the actions that the Suicide Prevention Partnership will deliver and make recommendations for how our wider partner organisations can contribute to reducing suicide in Surrey.

PRIORITY ONE: Understanding suicide and attempted suicide in Surrey.

Action 1.1: In order to deliver the actions below we will develop an information sharing protocol.

Action 1.2: We will develop proactive intelligence systems, such as a real-time suicide surveillance database.

Action 1.3: We will collate intelligence to develop an annual suicide report to enable us to understand the success of our strategy on reducing suicide locally.

Action 1.4: We will work together to better understand the risks and issues in the system, through the development of a system-wide suicide risk log to capture concerns that may contribute to suicide risk locally.

Action 1.5: We will ensure there is a process to share learning. We will work in partnership to develop a group to learn from suicides. This group will be responsible for reviewing deaths by suicide and suicide related significant events including: Prevention of future Deaths Notifications (PFDs) that the Coroner has issued, identifying and monitoring sudden unexpected deaths-suspected suicide, and Sudden Unexpected Incidents reports (SUIs) from Primary Care providers.

Action 1.6: Ensure that learning is implemented for example through the Never Event Framework (NHS, n.d.)**.**

Collecting and analysing local intelligence on the number of suicides, the context in which they occur, the groups most at risk and how the picture is changing over time, is critical for effective suicide prevention work. Data and intelligence informs the development of the suicide prevention strategy, provides an evidence base for action and provides the means to monitor and review progress. Effective use of intelligence allows us to ensure that we are effectively using the resources available to meet local needs.

Previously suicide audits have been the primary intelligence source to fulfil this function, however, these come with risks and limitations due to: potentially small numbers of cases, the time lapse between the suicide and the coroner verdict, and the fact they are resource intensive. These issues mean it is impossible to respond quickly to any local trends.

Surrey is seeking to move to real-time suicide surveillance. A key action from this strategy is therefore to agree an information sharing protocol which enables services to identify near misses and provide rapid support interventions where death has occurred and the coroner suspects suicide.

There are two potential models of delivery of real-time suicide surveillance – via police who are first responders, or coroners. Locally this will be determined by reviewing other areas that have successfully implemented real time data monitoring across a two-tier authority. In addition lessons can also be learnt via the pre-existing Surrey Multi-Agency Safeguarding Hub – drawing on the protocols and processes already embedded across the MASH partners, whilst exploring the expansion to identify triggers and protocols for suicide prevention.

Some suicide prevention partnerships in the country input into a shared risk log of emerging intelligence or risks in the system that may impact on suicide locally. This is used to set clear actions on how the risk can be mitigated and to highlight risks to appropriate local bodies.

This intelligence, alongside national data, can be collated annually to provide a more detailed understanding of the impact of our strategy locally.

In Surrey, there is a process to review suicides amongst people accessing secondary mental health care and adult substance misuse treatment services. However there is no process to learn from suicides amongst people accessing Primary Care or those unknown to services. A clear partnership process is needed to learn from all suicides. Any learning should be shared and implemented.

Recommendation 1.1: The Surrey Coroner to work with Public Health to develop a system to proactively assess suspected suicide cases and promptly report learning to the Surrey Suicide Prevention Partnership to inform local action.

Recommendation 1.2: Network Rail and British Transport Police to continue to share real-time intelligence on network incidents with the Public Health Team lead.

Recommendation 1.3: Surrey Police and the Office of the Police and Crime Commissioner to support the Surrey Suicide Prevention Partnership to establish a real-time intelligence database.

Recommendation 1.4: Mental Health Providers and Primary Care to contribute to the annual suicide report by collating and sharing learning from completed and attempted suicides of people in their care.

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PRIORITY TWO: Tailor approaches to improve emotional wellbeing in particular groups.

Action 2.1: We will coordinate the publicising of national and Surrey initiatives which target support messages to particular groups.

Action 2.2: We will work with the Time to Change Surrey and national Time to Change campaigns to reduce stigma around mental ill health, including particular target groups.

Action 2.3: We will adapt the Wheel of Wellbeing approach to also promote the emotional wellbeing of young people.

Action 2.4: We will support Surrey's Workplace Wellbeing Steering group to ensure evidence based mental health interventions are incorporated into their approach to working with employers.

Action 2.5: We will ensure that carers for people with people mental health needs are enabled with the knowledge, information and support to enable them to care for a person who has experienced suicidal thoughts, or has previously attempted suicide.

There are a number of programmes and initiatives nationally and locally that target particular populations to improve their mental wellbeing, these include:

- Men's Sheds Association (Mens Sheds Association, n.d.) and the several 'Men in Sheds' schemes running in Surrey, create the space for men to socialise and learn new skills
- The joint campaign between the Campaign Against Living Miserably (CALM) and Lynx, which raises awareness of mental wellbeing and male suicide (Calm Zone, n.d.).
- The national and Surrey Time to Change programmes that aim to reduce the stigma faced by people with mental ill health. Both programmes also target specific groups.
- The Wheel of Wellbeing (WoW), which is an evidence based set of six actions that people can take on an everyday basis that have been shown to improve mood, reduce the risk of depression, strengthen relationships, keep people healthy and add up to seven years to our lives. Surrey County Council has ran two campaigns on the WoW over the last two years which have been popular with local residents.
- Targeted Adolescent Mental Health Service (TAMHS) and Healthy Schools run a number of initiatives and programmes across Surrey to promote Emotional Health and Wellbeing among young people (Healthy Surrey, 2018).
- Other targeted work in Surrey is delivered through Public Health, Community Connections services, the voluntary sector, mental health services and other frontline services that work with vulnerable people.

There remain a number of gaps in targeted provision of emotional wellbeing initiatives to all groups that are at increased risk of mental ill health. A more coordinated approach to ensure all high risk groups are targeted and our collective resources are used to best effect is warranted to maximise the impact of these programmes.

Recommendation 2.1: Integrated Care Systems to ensure emotional wellbeing support is available to those recently diagnosed with Long Term Conditions as part of their care planning. And that the workforce are skilled in recognising and responding to mental health issues (such as depression and anxiety that often result from/accompany Long Term Conditions).

Recommendation 2.2: Schools to be supported and encouraged to have whole school emotional health and wellbeing plans for all pupils, and also include targeted programmes for those children and young people most at risk of mental ill health.

Recommendation 2.3: Surrey University to have a local suicide prevention plan. This should include promoting emotional wellbeing, access to support services and welfare support. The plan to also include signposting to bereavement support.

Recommendation 2.4: Surrey's Workplace Wellbeing Group to include interventions to promote emotional wellbeing and mental health within their framework to encourage and support business to improve the wellbeing of their staff. In addition, tailored support to high risk occupation groups should be part of this response.

Recommendation 2.5: Blue Light emergency services and NHS Trusts to raise awareness of mental health and wellbeing. Recognising the high risk occupations they employ, to also put in place preventative measures and to support staff who may be experiencing mental health issues to get work, stay in work and return to work.

Recommendation 2.6: All older adult services to improve the emotional and mental wellbeing of people accessing their services, and ensure that all staff are trained in basic suicide awareness.

PRIORITY THREE: Reduce access to means by promoting suicide safer communities.

Action 3.1: We will continue to monitor and respond to new and emerging methods of suicide.

Action 3.2: We will continue to monitor and respond to emerging high risk locations by working with our partners to lead the Suicide Safer Communities approach.

Action 3.3: We will continue to use the Samaritans media reporting guidelines to monitor local media and respond to any concerns.

The National Strategy Third Progress Report (Department of Health, 2017) highlights that in order to reduce access to means of suicide we should:

- Identify high risk locations.
- Put safeguards in place to prevent suicides.
- Be aware of emerging suicide methods.
- Work with local media around sensible reporting of suicide.

In Surrey, intelligence is shared between partners on the locations of suspected suicide to allow partners to respond. However, there is no uniformly agreed protocol by which to do this. Priority one seeks to address this.

In Surrey, we have a number of high risk rail locations identified by the Network Rail, Southern Railways and British Transport Police. We therefore have a strong partnership approach to working with these organisations. The previous Surrey Suicide Prevention Group has also worked closely with local authorities to put in place safeguards to prevent suicides in high risk locations (e.g. high buildings).

The Suicide Safer Communities Designation/Approach was developed by Living Works and launched in 2015 (Living Works, 2015). This approach identified 10 pillars of action to prevent suicide. Surrey has adopted aspects of this approach to guide concerted multi-agency action on suicide in high risk locations in Woking and Ashford. This has included:

- Training and awareness for the local community.
- Community mental health champions trained as gatekeepers.
- Reducing stigma around mental health and suicide.
- Promoting local services.

Recommendation 3.1: Surrey Coroner, Surrey Police, Public Health, Primary Care and Mental Health services to alert the Suicide Prevention Partnership of the location and means of suspected suicides, to enable a partnership response to reducing risks.

Recommendation 3.2: Boroughs and Districts to work with the Surrey Suicide Prevention Partnership to include suicide impact assessment in planning, to reduce access to means such as high risk locations, highways and buildings.

PRIORITY FOUR: Reduce attempted suicide and self-harm especially amongst children and young people – including those who have experienced adverse events.

Action 4.1: We will gain a better understanding of self-harm in Surrey by analysing local and national intelligence.

Action 4.2: We will raise awareness and understanding of self-harm in young people's settings through Time to Change Surrey and Healthy Schools programmes.

Self-harm is the single biggest predictor of suicide risk. The Government's Third Progress Report on Preventing Suicide in England (Department of Health, 2017), recognises the need to expand the scope of the National Strategy to include Self Harm in its own right. This follows rising concerns amongst professionals who work with children and young people and increasing hospital attendances for self-harm by females who are under 17.

A report by Young Minds highlights that 1 in 3 adult mental health conditions is related to adverse childhood experiences (Young Minds, 2016). These experiences include neglect, abuse, poverty, parental alcohol or substance misuse, parental poor physical or mental health and parental suicide. Adverse childhood experiences increase the risk of suicide (Devaney, Northern Ireland). It is therefore important that professionals/staff supporting children and young people that may have experienced adverse events, are trained to recognise and respond to signs of self-harm, poor mental health and suicidal ideation. It is also important for staff to deliver proactive work around parenting, education and awareness and support for families.

Many children and young people who self-harm feel guilty and afraid – there is often a fear of being labelled as attention seeking. The stigma around self-harm stops young people accessing support (Mental Health Foundation, 2012). It is important to embed awareness and understanding of self-harm in young people's settings and in training for staff who work with them.

NICE guidance on Self Harm (NICE, 2013) provides a series of quality standards for the provision of longer-term support for children and young people (aged 8 to 18) and adults (aged 18 and over) who self-harm. It calls for rapid access to assessment and treatment.

However, mental health training is patchy for those working in family support and youth service roles. Furthermore, in Surrey, whilst we have access to data on self-harm resulting in a hospital attendance, not every incident of self-harm will require hospital treatment. As a result we do not have an accurate understanding of self-harm within Surrey. There is therefore, more we can do locally to prevent and respond to suicide and self-harm among young people.

Recommendation 4.1: NHS Trusts to audit current practice against the NICE guidelines on self-harm and ensure adherence. **Specifically to**:

- Ensure that people who present to Emergency Departments following self-harm receive a psychosocial assessment and appropriate care.
- Raise awareness among staff of the complex issues contributing to self-harm.
- Understand the role of safeguarding.

Recommendation 4.2: Children's services to ensure a strategic response to building resilience and mitigating the impact of social media on young people's emotional wellbeing.

9 **Recommendation 4.3:** Children's services to ensure children who are looked after and those who have had adverse childhood experiences receive the support/treatment they need.

PRIORITY FIVE: Provide better information and support to those bereaved by suicide.

Action 5.1: We will work with partners across the South East to advocate for improved access to postvention support, including working with the voluntary sector to expand postvention support.

"The term postvention describes activities developed by, with or for people who have been bereaved by suicide, to support their recovery and to prevent adverse outcomes, including suicide and suicidal ideation." (NSPA, 2017).

Increasing the number of postvention services is a key aspiration of the National Suicide Strategy, highlighting significant unmet need nationally. Postvention services can work to reduce the health inequalities that friends, families, colleagues and partners experience (Public Health England, 2016).

Postvention support in Surrey has been developed and provided by the voluntary sector:

Lucy Rayner Foundation
A local charity, the Lucy Rayner Foundation set up the 'Surrey Suicide Bereavement Service' in 2018. This service offers one-to-one support to people bereaved by suicide. The support includes listening, advocacy, signposting and access counselling.

CRUSE
The national charity CRUSE offers a bereavement Care Free-phone National Helpline. This is staffed by trained bereavement volunteers, who offer emotional support to anyone affected by bereavement. Locally in Surrey CRUSE also offer bereavement counselling.

Survivors of Bereaved by Suicide (SOBS)
SOBS offer two support groups in Surrey (Guildford and Sutton) that meet once each month. The groups are led by a volunteers, most of whom have been bereaved by suicide. These groups provide an opportunity to listen, to share, to ask questions and to connect with others.

The Compassionate Friends
The Compassionate Friends is a national charity for people bereaved by the death of a child of any age. They support people through a telephone helpline, online support and local support groups.

"The first two weeks are critical to have someone there for you. Luckily for us we had a wonderful couple who invited us to their home and my husband and I just sat in shock whilst they talked words of understanding, they had lost their daughter a year before. They listened to us whilst we poured our heart out, cried in despair at the unfairness of life. They served us coffee and cakes, then we spoke some more. This was what helped us."
Jenny Rayner talking about informal support received from social network

Developing postvention support

In Surrey, focus groups and conversations carried out by the Public Health Team, Citizen Advice Bureau, Lucy Rayner Foundation and SOBS identified that there is a demand for a practical* support service to provide postvention support promptly to people bereaved by suicide. *(practical meaning more than just written information). The current level of provision, whilst hugely valued, is deemed as insufficient to meet the size of the local demand. Postvention provision for Surrey should include:

- Emotional support.
- Social and welfare advice and advocacy.
- Signposting to other services.
- Support to access long term emotional support.

Funding postvention

Suicide bereavement services in Surrey are not funded by Surrey health and social care commissioners. The above charities fundraise and apply for ad hoc grants to deliver these services. Therefore they are vulnerable if they fail to fundraise the cost to deliver the service. To maintain and further develop postvention support it is important that there is sustainable funding allocated to postvention.

Recommendation 5.1: Surrey Coroner and Surrey Police to provide families bereaved by suicide with the Help is at Hand booklet (NSPA and PHE, 2015) and information on local services.

Recommendation 5.2: Integrated Care Systems to consider funding postvention services in Surrey.

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PRIORITY SIX: Prevention of suicide among identified high risk groups, particularly those with mental ill health.

Action 6.1: We will establish an annual coordinated training plan for mental health awareness and suicide prevention targeted to high risk groups.

Action 6.2: We will promote the bitesize e-learning on suicide prevention in communities with the highest suicide rates, to empower people to notice and respond to signs that someone may be at risk.

Reducing the risk of suicide in key high risk groups is a key action identified in the national Suicide Prevention Strategy (2012) and third progress report (Department of Health, 2017).

People known to mental health services

Nationally, there is a drive to aim for zero suicides among those in the care of mental health settings. Surrey and Borders Partnership NHS Foundation Trust are responding to this through the development of a strategic approach for their organisation comprising five strands:

- Prevention of suicide among high risk groups.
- Reducing access to means.
- Better support for those bereaved by suicide.
- Training and education.
- Effective use of data and intelligence.

People with co-occurring mental health and substance misuse needs

It is very common for people to experience problems with their mental health and alcohol/drug use (co-occurring conditions), at the same time. Research shows that mental health problems are experienced by the majority of drug (70%) and alcohol (86%) users in community substance misuse treatment.

Death by suicide is also common in this group, with a history of alcohol or drug use being recorded in 54% of all suicides in people experiencing mental health problems. Other evidence tells us that people with co-occurring conditions have a heightened risk of other health problems and early death. We also know that in spite of the shared responsibility that NHS and local authority commissioners have to provide treatment, care and support – people with co-occurring conditions are often excluded from services (Public Health England, 2017).

It is important that we use our collective influence and resources to ensure timely and effective responses for people with co-occurring mental health and substance misuse needs, in order to: improve access, reduce harm, improve health, enhance recovery, and to prevent exclusion.

Building skills and capacity of staff

Essential to reducing the risk of suicide among high risk groups is identifying the skills and capacity needs of local workforces that have contact with high risk groups. Then to develop innovative training and education solutions to meet those needs. This is a specific recommendation in the NHS Five Year Forward View for Mental Health (NHS England, 2017) and Public Health England's public mental health leadership and workforce development framework (PHE, 2015).

Health Education England published suicide prevention competency frameworks (Health Education England, 2018). The frameworks describe the activities that need to be brought together, to support people who self-harm and/or are suicidal, and identify key populations:

1. Working with children and young people.
2. Working with adults and older people.
3. Working with the public.
4. Service users and carers.

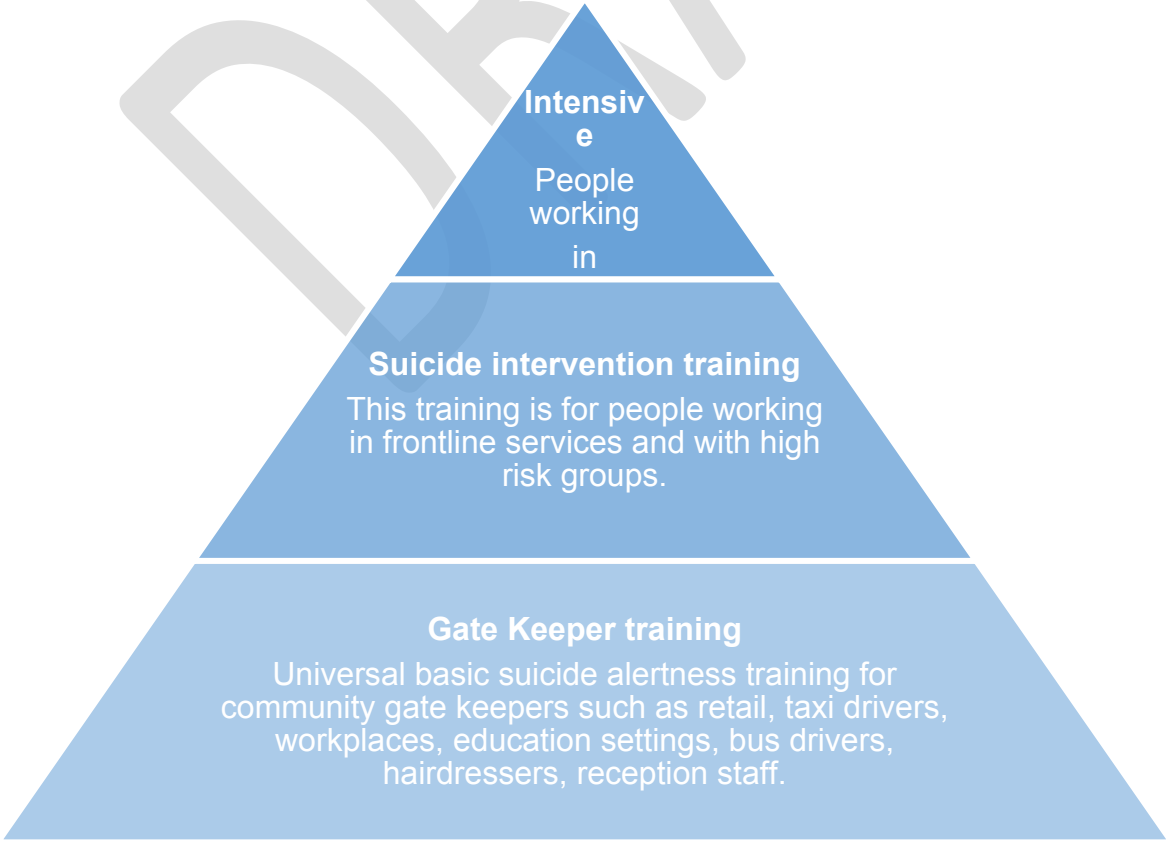
Key activities in the framework include:

- Developing training curricula for practitioners from a range of clinical and professional backgrounds.
- Evaluating existing training.
- Evaluating practice in existing services.
- Reflecting on and supervising individual professional practice.
- Identifying good practice and helping those receiving support to understand what they can expect from their care.

In Surrey we have a long established history of providing suicide prevention training in Surrey. However the level of training varies and this is not jointly commissioned in order to ensure a robust approach that: meets local needs, targets all high risk groups identified in section 4 and makes effective use of limited resources.

In Surrey suicide prevention training is commissioned and delivered using three approaches (see Figure 6). This model is based on national guidance from Public Health England and Health Education England (PHE and HEE, 2016).

Figure 6: Suicide Prevention Training Approaches in Surrey



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Recommendation 6.1: Surrey and Borders NHS Partnership Foundation Trust follows the Secretary of State's 2018 zero suicide ambition for mental health inpatients (NHS England, 2017).

Recommendation 6.2: HMP Prisons, Probation Service and Surrey Police to ensure staff are competent in identifying and responding to suicide risk.

Recommendation 6.3: Substance Misuse Services and commissioners to ensure staff are trained to assess suicide risk and that there are clear pathways into Mental Health support and assessment.

Recommendation 6.4: Mental health support services and commissioners to ensure staff are trained to assess substance misuse needs and make referrals to substance misuse services.

Recommendation 6.5: There is continued investment in safe havens and crisis support in high risk areas. Commissioners and providers must ensure that these services are promoted in the local community as part of suicide prevention awareness.

Recommendation 6.6: CCGs to recommend/encourage staff working in Primary Care to be trained to recognise and respond to suicidal risk, thoughts and behaviours in line with the Health Education England self-harm and suicide prevention frameworks (Health Education England, 2018).

Recommendation 6.7: CCGs, Primary Care and secondary mental health services to have a clear communicated care pathway to ensure the transfer of care between primary care and secondary mental health care services and vice versa, as set out in the Five Year Forward View for Mental Health (NHS England, 2017).

7. How we will work together to achieve this?

A successful multi-agency partnership is integral to suicide prevention and this includes partners in both statutory and voluntary organisations. Figure 7 below from the National Suicide Prevention Alliance shows the partners needed to deliver effective suicide prevention. Therefore we will contact and request representatives from these partners to attend the new Suicide Prevention Partnership.

Figure 7: Partners needed to deliver effective suicide prevention

Source: National Suicide Prevention Alliance

Multi-Agency partnerships can enable: improved integration of health and social care support, the pooling of resources, sharing of information, and implementation of a population health management approach to suicide prevention. This allows for responsive, community-wide strategies that are not restricted by service boundaries.

We have a long history of working closely with our partners including statutory and voluntary mental health providers; health, social care and local government. This strategy aims to build

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on the good practice and work of the previous Suicide Prevention Group, to co-ordinate multi-agency working to deliver evidence based suicide prevention interventions.

This strategy will support the emerging Integrated Care System's* commitment to reducing suicide as part of the Mental Health Five Year Forward View. *(responsible for health and care services in Surrey).

This strategy will also support and dovetail with the Emotional Wellbeing Mental Health Strategy for Children and Young People in Surrey 2019-22.

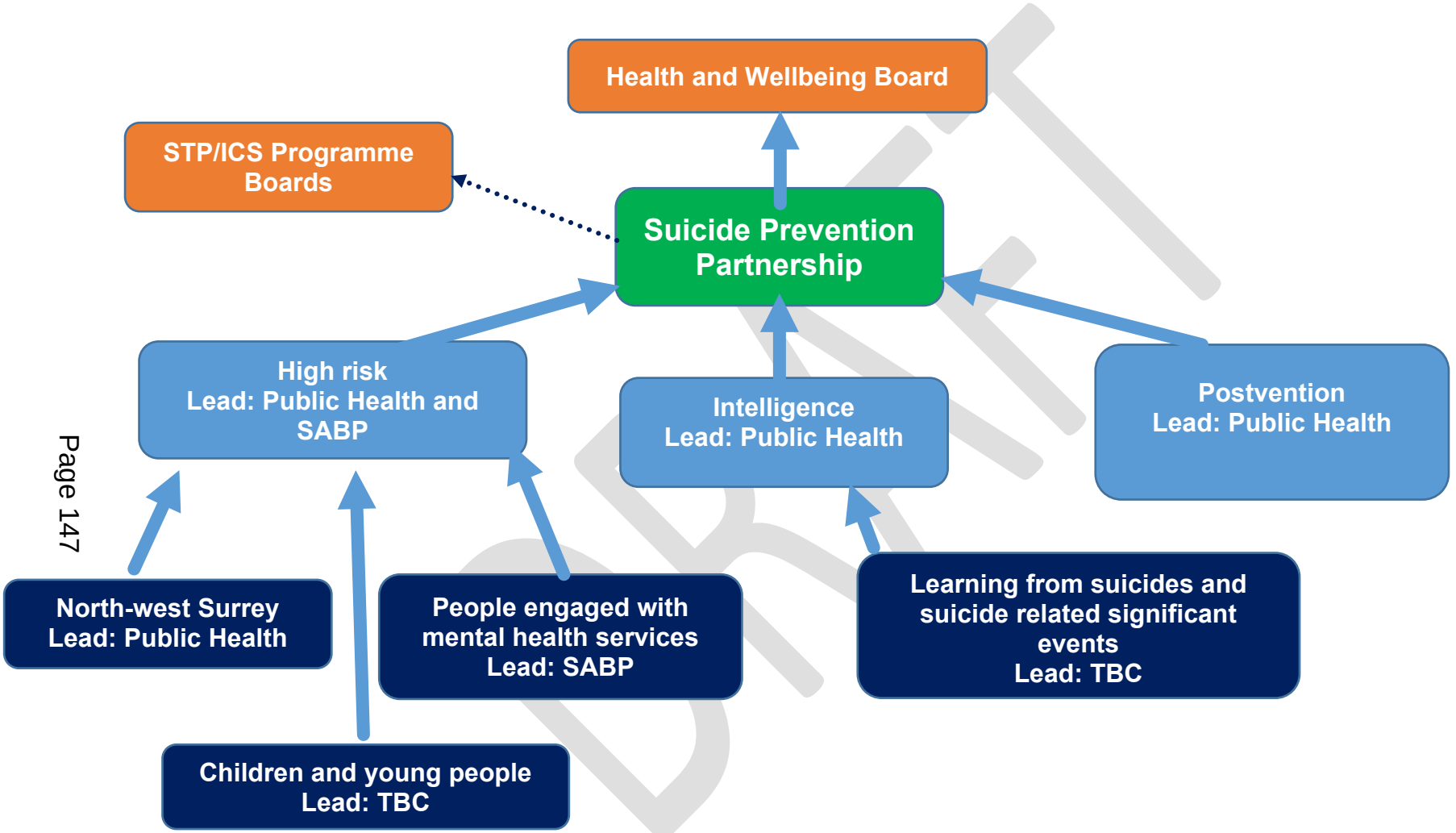
Governance

The actions within this Suicide Prevention Strategy will be delivered by Surrey's Suicide Prevention Partnership (see Figure 7 for the partners needed). This Partnership will be set up within three months of the strategy being signed off. This group will report to the Health and Wellbeing Board. See Figure 8 below.

The Suicide Prevention Partnership will develop and oversee with partners a delivery work plan for each priority area and seek support from the Health and Wellbeing Board to hold partners to account for delivery. This will be agreed within the first six months of the strategy.

There are a number of inter-dependencies with other partnership groups and/or organisations. Members of the Suicide Prevention Partnership are to actively champion suicide prevention in other partnership groups.

Figure 8: Proposed governance structure



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Annex 1 – Summary of Actions

PRIORITY ONE: Understanding suicide and attempted suicide in Surrey

Action 1.1: In order to deliver the actions below we will develop an information sharing protocol.

Action 1.2: We will develop proactive intelligence systems such as a real-time suicide surveillance database.

Action 1.3: We will collate intelligence to develop an annual suicide report to enable us to understand the success of our strategy on reducing suicide locally.

Action 1.4: We will work together to better understand the risks and issues in the system, through the development of a system-wide suicide risk log to capture concerns that may contribute to suicide risk locally.

Action 1.5: We will ensure there is a process to share learning. We will work in partnership to develop a group to learn from suicides. This group will be responsible for reviewing deaths by suicide and suicide related significant events including: Prevention of future Deaths Notifications (PFDs) that the Coroner has issued, identifying and monitor sudden unexpected deaths – suspected suicide, and Sudden Unexpected Incidents reports (SUIs) from Primary Care providers.

Action 1.6: Ensure that that learning is implemented for example through the Never Ever Event Framework (NHS, n.d.).

PRIORITY TWO: Tailor approaches to improve emotional wellbeing in particular groups

Action 2.1: We will coordinate the publicising of national and Surrey initiatives which target support messages to particular groups.

Action 2.2: We will work with the Time to Change Surrey and national Time to Change campaigns to reduce stigma around mental ill health, including particular target groups.

Action 2.3: We will adapt the Wheel of Wellbeing approach to promote the emotional wellbeing of young people.

Action 2.4: We will support Surrey's Workplace Wellbeing Steering group to ensure evidence based mental health interventions are incorporated into their approach to working with employers.

Action 2.5: We will ensure that carers for people for people mental health needs are enabled with the knowledge, information and support to enable them to care for a person who has experienced suicidal thoughts, or has previously attempted suicide.

PRIORITY THREE: Reduce access to means by promoting suicide safer communities

Action 3.1: We will continue to monitor and respond to new and emerging methods of suicide.

Action 3.2: We will continue to monitor and respond to emerging high risk locations by working with our partners to lead the suicide safer communities approach.

Action 3.3: We will continue to use the Samaritans media reporting guidelines to monitor local media and respond to any concerns.

PRIORITY FOUR: Reduce attempted suicide and self-harm especially amongst children and young people - including those who have experienced adverse events.

Action 4.1: We will gain a better understanding of self-harm in Surrey by analysing local and national intelligence.

Action 4.2: We will raise awareness and understanding of self-harm in young people's settings through Time to Change Surrey and Healthy Schools programmes**.**

PRIORITY FIVE: Provide better information and support to those bereaved by suicide

Action 5.1: We will work with partners across the South East to advocate for improved access to postvention support, including working with the voluntary sector to expand postvention support**.**

PRIORITY SIX: Prevention of suicide among identified high risk groups particular those with mental ill health

Action 6.1: We will establish an annual coordinated training plan for mental health awareness and suicide prevention targeted to high risk groups.

Action 6.2: We will promote the bitesize e-learning on suicide prevention in communities with the highest suicide rates, to empower people to notice and respond to signs that someone may be at risk.

9 Summary of Recommendations

Lead Organisations	Recommendation	Signed off by (Person or Board)
NHS Trusts	**1.4**: Mental Health Providers and Primary Care to contribute to the annual suicide report by collating and sharing learning from completed and attempted suicides of people in their care. **2.5**: Blue Light emergency services and NHS Trusts to raise awareness of mental health and wellbeing, and recognising the high risk occupations they employ, to put in place preventative measures and to support staff who may be experiencing mental health issues –to get work, stay in work and return to work. **4.1**: NHS Trusts to audit current practice against the NICE guidelines on self-harm and ensure adherence specifically: - Ensuring that people who present to Emergency Departments following self-harm receive a psychosocial assessment and appropriate care. - Raise awareness among staff of the complex issues contributing to self-harm. - Understand the role of safeguarding.	
Mental Health services	**1.4**: Mental Health Providers and Primary Care to contribute to the annual suicide report by collating and sharing learning from completed and attempted suicides of people in their care. **3.1**: Surrey Coroner, Surrey Police, Public Health England, CCGs and Mental Health services to alert the Suicide Prevention group of the location and means of suspected suicides, to enable a partnership response to reducing risks. **6.1:** Surrey and Borders NHS Partnership Foundation Trust follows the Secretary of State's 2018 zero suicide ambition for mental health inpatients (NHS England, 2017). **6.5:** There is continued investment in safe havens and crisis support in high risk areas. Commissioners and providers must ensure that these services are promoted in the local community as part of suicide prevention awareness.	

	6.7: CCGs and secondary mental health services to have a clear communicated care pathway to ensure the transfer of care between primary care and secondary mental health care services, and vice versa, as set out in the Five Year Forward View for Mental Health (NHS England, 2017).	
Primary Care, CCGs and Integrated Care Systems (ICSs)	**1.4**: Mental Health Providers and Primary Care to contribute to the annual suicide report by collating and sharing learning from completed and attempted suicides of people in their care. **2.1:** ICSs to ensure emotional wellbeing support is available to those recently diagnosed with Long Term Conditions as part of their care planning. And that the workforce are skilled in recognising and responding to mental ill health (that often results from/accompanies Long Term Conditions). **3.1:** Surrey Coroner, Surrey Police, Public Health England, CCGs and Mental Health services to alert the Suicide Prevention group of the location and means of suspected suicides, to enable a partnership response to reducing risks. **5.2**: Integrated Care Systems to consider funding postvention services in Surrey. **6.5:** There is continued investment in safe havens and crisis support in high risk areas. Commissioners and providers must ensure that these services are promoted in the local community as part of suicide prevention awareness. **6.6:** CCGs to recommend/encourage staff working in Primary Care to be trained to recognise and respond to suicidal risk, thoughts and behaviours in line with the Health Education England self-harm and suicide prevention frameworks (Health Education England, 2018). **6.7:** CCGs, Primary Care and secondary mental health services to have a clear communicated care pathway to ensure the transfer of care between primary care and secondary mental health care services and vice versa, as set out in the Five Year Forward View for Mental Health (NHS England, 2017).	

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Commissioners	**6.3:** Substance Misuse Services and commissioners to ensure staff are trained to assess suicide risk and that there are clear pathways into Mental Health support and assessment. **6.4:** Mental health support services and commissioners to ensure staff are trained to assess substance misuse needs and make referrals to substance misuse services. **6.5:** There is continued investment in safe havens and crisis support in high risk areas. Commissioners and providers must ensure that these services are promoted in the local community as part of suicide prevention awareness.	
District and Boroughs and Surrey County Council	**2.4**: Surrey's Workplace Wellbeing Group to include Interventions to promote emotional wellbeing and mental health within their framework to encourage and support business to improve the wellbeing of their staff. In addition, tailored support to high risk occupation groups should be part of this response. **3.2**: Boroughs and Districts to work with the Surrey Suicide Prevention Partnership to include suicide impact assessment in planning to reduce access to means such as high risk locations, highways and buildings.	
Prisons and Probations	**6.2:** HMP Prisons, Probation Service and Surrey Police to ensure staff are competent in identifying and responding to suicide risk.	
Coroner	**1.1:** For the Coroner to work with Public Health to develop a system to proactively assess suspected suicide cases and promptly report learning to the Surrey Suicide Prevention Partnership to inform local action. **3.1**: Surrey Coroner, Surrey Police, Public Health England, CCGs and Mental Health services to alert the Suicide Prevention group of the location and means of suspected suicides, to enable a partnership response to reducing risks. **5.1:** Surrey Coroner and Surrey Police to provide families bereaved by suicide with the Help is at Hand booklet (NSPA and PHE, 2015) and information on local services.	

Network Rail and British Transport Police	**1.2**: For Network Rail and British Transport Police to continue to share real-time intelligence on network incidents with the Public Health Team lead.	
Surrey Police	**1.3**: For Surrey Police and the Office of the Police and Crime Commissioner to support the Surrey Suicide Prevention Partnership to establish a real-time intelligence database **3.1:** Surrey Coroner, Surrey Police, Public Health England, CCGs and Mental Health services to alert the Suicide Prevention group of the location and means of suspected suicides, to enable a partnership response to reducing risks. **5.1:** Surrey Coroner and Surrey Police to provide families bereaved by suicide with the Help is at Hand booklet (NSPA and PHE, 2015) and information on local services. **6.2:** HMP Prisons, Probation Service and Surrey Police to ensure staff are competent in identifying and responding to suicide risk.	
Substance Misuse Services	**6.3:** Substance Misuse Services and commissioners to ensure staff are trained to assess suicide risk and that there are clear pathways into Mental Health support and assessment. **6.4:.**Providers and commissioners must ensure that Safe Havens are promoted in the local community as part of suicide prevention awareness.	
Children's Services	**4.2**: Children's services to ensure a strategic response to building resilience and mitigating the impact of social media on young people's emotional wellbeing. **4.3**: Children's services to ensure children who are looked after and those who have had adverse childhood experiences, receive the support/treatment they need.	
Schools/Colleges/ Universities	**2.2**: Schools should be supported and encouraged to have whole school emotional health and wellbeing plans that also include targeted programmes for those children and young people most at risk of mental ill health.	

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	2.3: Surrey University to have a local suicide prevention plan. This should include promoting emotional wellbeing, access to support services and welfare support. The plan should also include signposting to bereavement support.	
Older Adult Services	**2.6**: All older adult services to improve the emotional and mental wellbeing of people accessing their services; and ensure that all staff are trained in basic suicide awareness.	

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