Board of Directors Meeting

SUMMARY REPORT	Meeting Date:	25/09/2024
	Agenda Item:	13

Report Title:	**Suicide Prevention in England – Progress Report**	
Author(s):	Darren McCarthy - Clinical Risk & Patient Safety Advisor	
Accountable Director:	Helen Crimlisk – Interim Medical Director	
Other meetings this paper has been presented to or previously agreed at:	**Committee/Tier 2 Group/Tier 3 Group**	Presented at EMT Presented at QAC
	Date:	15/08/2024 and 11/09/2024 respectively
Key points/ recommendations from those meetings	Report approved and additional information requested which has been reflected in the onward report to the Board.	

Summary of key points in report

Executive Summary

1. This report outlines the key findings from the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) Annual Report for 2024 and the new Suicide Prevention Strategy for England: 2023 to 2028.

2. The report outlines the work being undertaken in SHSC to ensure a continued focus on suicide prevention to reduce the risk of suicide in SHSC service users. It reports how this will be shared and incorporated into the SHSC Suicide Awareness Training offer.

3. The report outlines the work being undertaken with the Director of Public Health and partners to support the development of an updated Sheffield City-wide Suicide Strategy.

4 Whilst the report identifies less well known or new risk factors relating to neurodiversity, sexuality, young people, women of childbearing age, other inequalities and identifies the additional risk of gambling disorders, Quality Assurance Committee asked that it be made clear that it is important to note that the key message that those at highest risk remain men in middle age living with comorbid physical health and substance misuse disorders and living in relative poverty.

Recommendation for the Board/Committee to consider:

Consider for Action		Approval		Assurance	x	Information	x

The Board is asked to review and comment on the report and to take assurance from the work outlined.

Please identify which strategic priorities will be impacted by this report:				
Effective Use of Resources	*Yes*	*x*	*No*	
Deliver Outstanding Care	*Yes*	*x*	*No*	
Great Place to Work	*Yes*	*x*	*No*	
Ensuring our services are inclusive	*Yes*	*x*	*No*	

Is this report relevant to compliance with any key standards ?					**State specific standard**
Care Quality Commission Fundamental Standards	*Yes*	*x*	*No*		**SAFE**
Data Security and Protection Toolkit	*Yes*		*No*	*x*	
Any other specific standard?					

Have these areas been considered ? YES/NO					If Yes, what are the implications or the impact? If no, please explain why
Service User and Carer Safety, Engagement and Experience	*Yes*	*x*	*No*		The impact of the report feeds into the training delivered around suicide in SHSC, and therefore is a key patient safety driver.
Financial (revenue &capital)	*Yes*		*No*	*x*	
Organisational Development /Workforce	*Yes*	*x*	*No*		Continuing professional development for SHSC staff in the form of mandatory training for registered clinicians.
Equality, Diversity & Inclusion	*Yes*	*x*	*No*		Suicide prevention is a key component of reducing inequalities because people with a range of protected characteristics are at increased risk of death by suicide
Legal	*Yes*		*No*	*x*	
Environmental sustainability	*Yes*		*No*	*x*	

Name of Report

Suicide Prevention in England Progress Report

Section 1: Analysis and supporting detail

Background

1.1 Background

Death by suicide is a tragedy for individuals, families and communities, and its prevention is a public health and clinical priority. Although most people who die by suicide are not known to mental health services, the presence of mental health problems (particularly mood disorders) is a significant risk factor for death by suicide. People with mental health problems who are receiving specialist mental health care are disproportionally more likely to die by suicide. Every death by suicide is a tragedy for the person involved and also for the family and community who are impacted by it.

The annual report of the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) was published February 2024. The new 5-year National Suicide Prevention Strategy (Suicide prevention strategy for England: 2023 to 2028) was published in September 2023. The publication influences the national and local strategies.

Suicide prevention also requires wider cooperation and coordination than that at the level of an individual organisation. SHSC is a key part of the broader Sheffield and South Yorkshire programmes on suicide prevention and is contributing to the development of a new City-wide Suicide Prevention Strategy with partners from across the city.

The current paper applies the national findings from NCISH to the work that SHSC is undertaking in areas that have the potential to impact on suicide prevention in service users of SHSC, via the implementation of the Clinical and Social Care Strategy, Therapeutic Environments Programme and developments in SHSC's Suicide Awareness Training.

1.2 Suicide in the UK General Population 2011 - 2021

There were 69,420 suicides in the general population in the UK between 2011 and 2021, an average of 6,311 deaths per year. There has been an overall increase in

deaths by hanging / strangulation and self-poisoning. The number of deaths by cutting or stabbing has continued to rise.

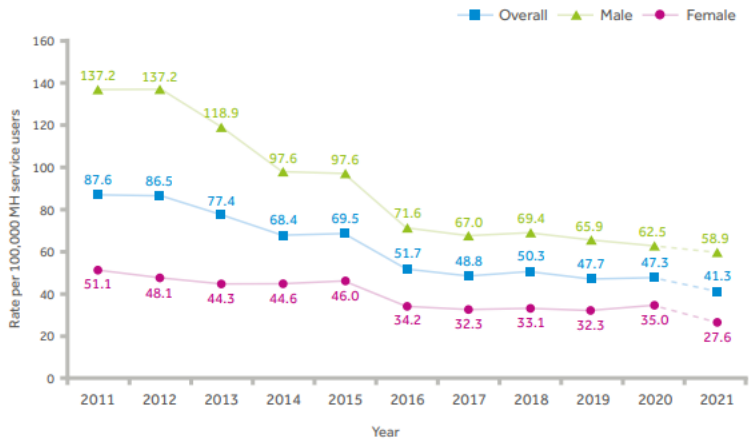
Factors such as socioeconomic adversity, use of alcohol and drugs, physical health, male gender, age, and contact with the criminal justice system were seen to be relevant to suicide prevention in the General Population. The report also highlights areas which need particular attention including an enhanced focus on inequalities, protected characteristics, those using substances and those with a history of trauma.

1.3 Suicide in Mental Health Patients in the UK 2021 - 2021

There were 18,339 mental health patients (defined as people in contact with mental health services within 12 months of death), who died by suicide during this period (an average of 1667 deaths per year). This represents over a quarter (26%) of suicides.

The rates of suicide have continued to fall over the last 20 years, including over the COVID period, however the rate of improvement has slowed over the last 5 years.

Figure 8: Rates of suicide per 100,000 mental health service users[1] in England

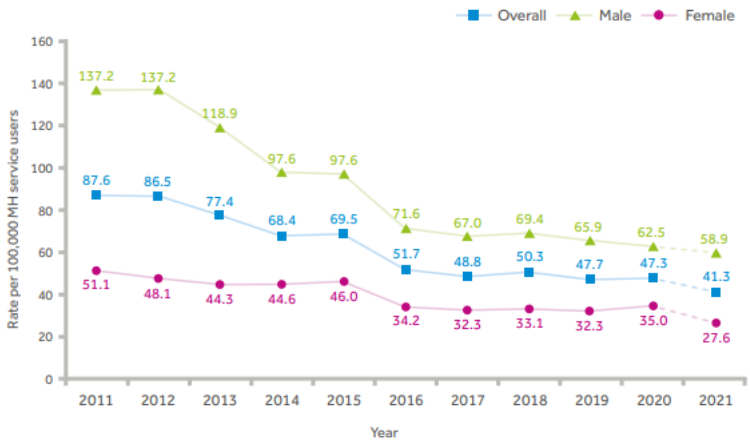


In the UK, the number of deaths by hanging/strangulation rose steeply in 2018-2021, especially in female patients and in patients aged under 25. The number of deaths by self-poisoning also increased in 2018-2020 but this appears to have fallen in 2021. The main substances taken in fatal overdose overall were opiates/opioids and the source was most often by prescription.

1.4 Suicide in Acute Mental Health Care Settings 2011 - 2021

There were 3767 mental health patients who died by suicide under acute mental health care settings. 6% were in-patients, 14% were post-discharge care and 13% were under crisis and home treatment teams. Of the estimated 74 suicides by mental health in-patients in the UK, a quarter (28%) died whilst under enhanced nursing observation (i.e., frequent – every 15-30 minutes – checks on a patient or being with them constantly). Most were detained and most died in the first week of admission. The highest risk period for patients discharged was in the first 1-2 weeks post discharge.

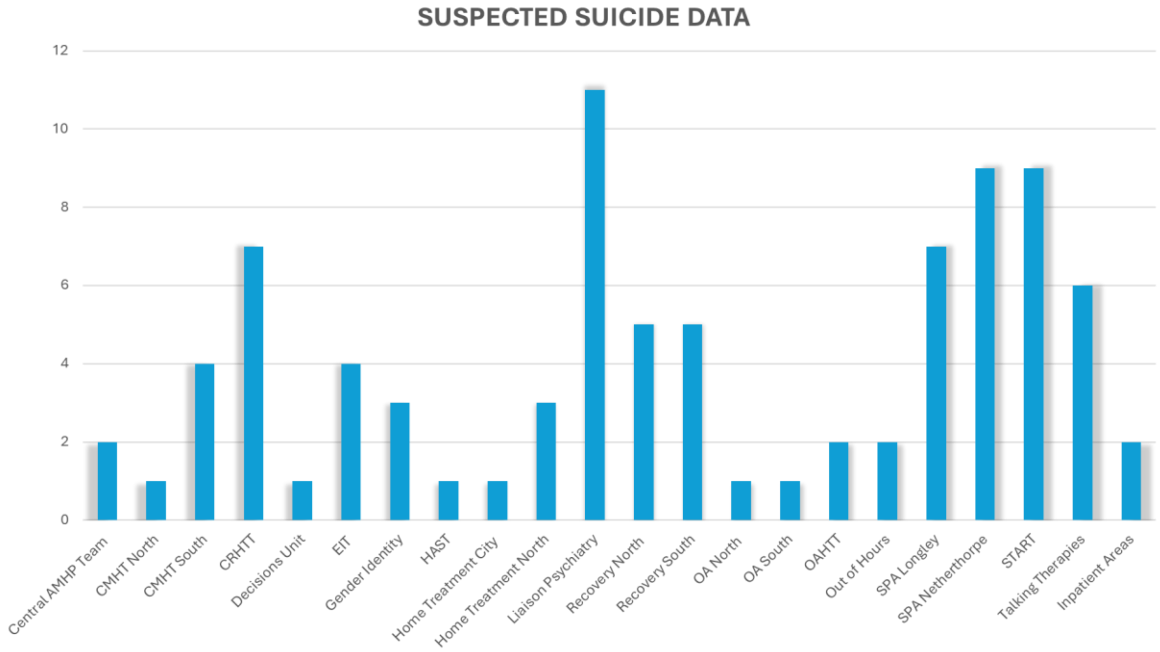
Figure 8: Rates of suicide per 100,000 mental health service users[1] in England



1.5 Suicide in SHSC by Service Settings Review January 2021 to June 2024

During the period January 2021 to June 2024 there were 87 suspected suicides in SHSC. Of the 87 deaths 2 were reported in inpatient settings; 1 occurring on a step-down residential unit, 1 while on leave from an acute ward.

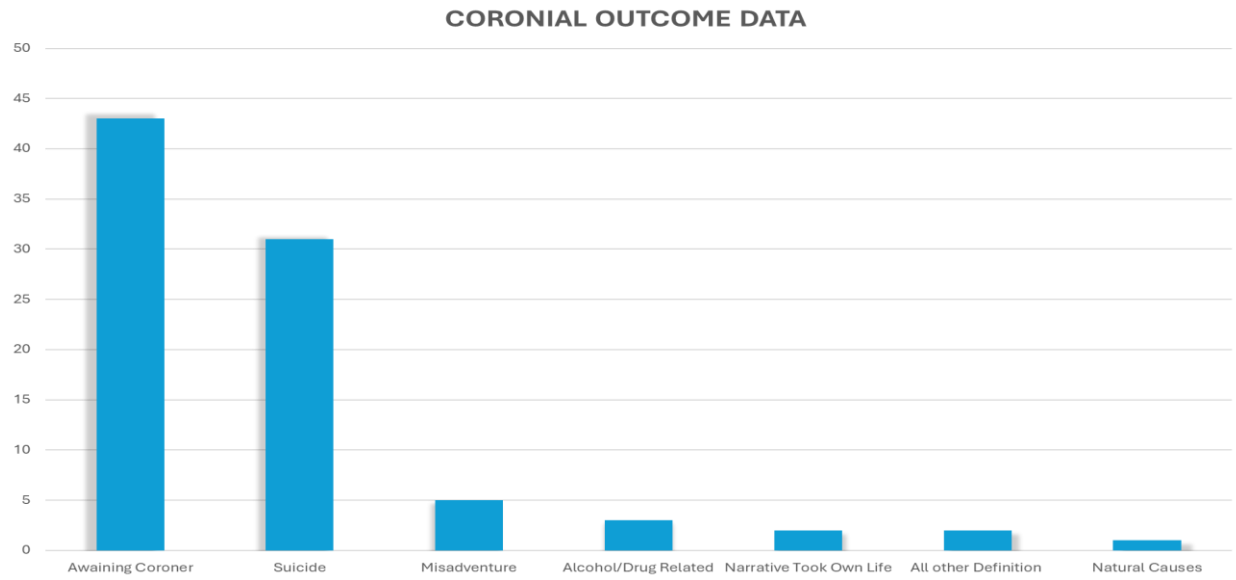
The 85 deaths in the community were from a variety of different settings, as detailed below:



There were no areas identified that had anomalous numbers of suspected suicides, however as expected areas dealing with those in crisis or new referrals to the services saw a higher number of suspected suicides (Psychiatric Liaison/SPA).

START services also had a higher average number, as would be expected given additional known risks with drug and alcohol use in suicidality, however START numbers only cover the period January 2021 to December 2022, when the service was no longer under SHSC.

However, while these incidents were categorised by SHSC staff on receipt of the information/incident details, not all these incidents were later categorised as suicide deaths following the coronial processes. Only 31 of the 87 suspected suicide deaths were primarily recorded as being suicide by South Yorkshire Coroner's Office. Full breakdown of classifications below:



1.6 **Learning Outcomes from Serious Investigations**

Since November 2023 SHSC has adopted the new Patient Safety Incident Response Framework (PSIRF), replacing the previous Serious Investigation Framework (SIF). However, data has been used for the purposes of learning from the previous investigations undertaken under the SIF process (as no investigations have yet been completed under PSIRF currently).

Much of the learning into suspected suicides/unexpected deaths had no real bearing on the incident itself, nor did it present any direct learning around suicide prevention that was not already known through the NCISH/national data.

Much of the learning from the investigations did not fit into the 'contributary factors' or 'missed opportunities' sections of the investigation, with the majority forming the 'lessons learnt' section. Much of the lessons learnt related to information around service procedures, showing that recommendations reflect system issues, as opposed to patient safety issues. Below are some examples taken from SHSC investigation recommendations:

- Ensure there are processes in place for Junior Doctors/on-call doctors working in areas they have not previously worked or in competencies that are required i.e. full crisis assessments
- Liaison Psychiatry to ensure there is a clear escalation process for staff new to the team for support and quality assurance of assessments
- Review joint working process/communication between Primary Care Mental Health Team and SHSC
- That the contents of this report be shared with the South Recovery Team for learning, and all Community Mental Health Teams to be reminded of the safeguarding adults policy
- Review the options for people in crisis out of hours, where A&E attendance is not considered to be suitable.

The above information aligns with the move away from investigating all suicides in line with the new PSIRF guidance, as it has been shown that the learning from investigation suicide is extremely limited. This has led SHSC to develop and provide 'Human Factors and Systems Thinking' training starting in 2022 and the subsequent 'PSIRF Human Factors and Systems Thinking Update' training which was launched in 2024.

Learning from incidents is now completed locally within the teams in After Action Reviews and Learning Responses, allowing quicker learning from incidents that is

within the teams the incident occurs. This allows for patient safety incidents to be quickly responded to, sharing learning with the areas where the incidents occurred.

However thematic reviews and Structured Judgement Reviews are also used to look at the wider patient safety issues that may present as a system issue. In these reviews information from a variety of sources is analysed to identify system issues, and then make actions and recommendations on how to improve the systems. Systems by their very nature are designed to support patient safety, however these systems are prone to atypical/unexpected failures, circumvention with humans, or changes to ways of working where the systems have not been adapted to the changes. By using this sort of learning we can develop changes to the system to support our services users and staff safety.

Currently there have been 2 Patient Safety Incident Investigations (PSII) commissioned, which is under the PSIRF framework, and therefore once completed the review of learning outcomes can be explored.

Many of the recommendations or actions that have come from learning/coronial processes aligns with the system thinking approaches discussed above. A recent Prevention of Future Death Notice highlighted record keeping and communication as an area for improvement directly linked to patient safety and suicide prevention. The recommendations from this have been incorporated into both the Suicide Awareness training and the Record Keeping Standards training.

1.7 **Autism and ADHD**

350 autistic people died by suicide, which equates to 2% of all patient suicides and an average of 32 deaths per year. There were 159 people with ADHD who died by suicide, 1% of all patient suicides and an average of 15 deaths per year. The number of autistic people and those with ADHD increased over this ten-year period, are likely a reflection of an increase in clinical recognition and diagnoses of these disorders over this period.

1.8 **Young People (Under 25)**

There has been recent concern over in-patient safety for young people. There were 117 deaths by suicide in in-patients who were aged under 25 (10-24 years) in 2011-21, an average of 11 deaths per year; 20 were aged under 18. In-patients under 25 who died showed high rates of clinical risk factors associated with suicide, including self-harm, alcohol and/or drug misuse, and childhood abuse. Half had been detained under Mental Health Act powers. They were more often under enhanced nursing observation. In 43% the admission was at a non-local unit.

There were 869 deaths by suicide by those identified as students, an average of 79 per year. 96 were “mental health patients”. This is a significantly lower proportion than other young people in the general population who died by suicide.

1.9 **Suicides following one-off assessment.**

There were 1001 deaths by people who had a one-off assessment with mental health services. They were more likely to have had a recent history of drug and alcohol misuse and recent adverse life events such as financial problems or relationship break up.

1.10 **Suicides in public places**

3894 patient suicides occurred in a public place an average of 354 per year. The most frequent places were pars, woodlands and railway networks with an increase in death by hanging or strangulation. Patients who died in a public place were more likely to have psychotic disorders, self-harm, drug use and life stressors.

1.11 **Characteristics of UK Mental Health patients who died by suicide in NCISH (2016 – 2021)**

Demographically, mental health patients who died by suicide were more likely to be male (66%) living alone (48%), unmarried (73%) and unemployed (48%). 7% were from an ethnic minority group. 5% identified as LGBT and 1% as trans or non-binary. 2% of patients were pregnancy or within a year of childbirth. Economic adversity was a risk factor for suicide, including loss of job, benefits and home. The majority (71%) had experienced recent adverse life events, particularly financial problems and relationship break up/divorce.

Clinically and behaviourally, of patients who died by suicide 63% had previously self-harmed, 47% had misused alcohol and 38% had misused drugs. They were most likely to have a diagnosis of a mood disorder or a psychotic condition such as schizophrenia, although people diagnosed with "personality disorder" were also at significant risk (11% of deaths). Individuals with "personality disorder" were more likely to have reported past trauma, including abuse, in their lives.

Amongst those from the LGBT+ community who died by suicide, there was an association with previous trauma and abuse.

1.12 **Suicide trends in the South Yorkshire and Sheffield General Population 2010-2020**

Yorkshire and the Humber, as a region, has had a consistently higher rate of suicide by comparison with the England average.

Sheffield has generally been below the average England suicide rate, although in 2018-2020 the local rate increased so that the Sheffield rate was higher. In context Sheffield had a lower suicide rate than Yorkshire and the Humber in 9/10 years in the decade 2010-2020, including in 2018-2020.

We do not currently have data in SHSC that is adjusted for population in a way to allow direct comparison with other local, regional and national data. This is an area for further development in our approach to suicide prevention. However, using the national NCISH data at SHSC we are aware that within the City of Sheffield the data nationally correlates to our local demographic data.

However, we do review the deaths of all service users who died by suicide or suspected suicide through the mortality review process and, where appropriate, through the Patient Safety Incident Reporting Framework (PSIRF) process. These processes report through to Quality Assurance Committee and Board of Directors.

We have been provided by NCISH with an SHSC rate of death by suicide of 8.65 per 10,000 people receiving mental health care for the period 2017-2019. This places SHSC in the group of NHS Mental Health Trusts with higher rates for that period. In the context of Yorkshire and the Humber, this region has had a consistently higher rate by comparison with the England average. Sheffield had a lower suicide rate than Yorkshire and the Humber in 9/10 years in the decade 2010-2020, including in 2017-2020.

Yorkshire and the Humber is a large rural area, which is known to be a factor in increased suicidality through factors such as isolation, access to means (higher proportion of farming and veterinary professionals), however this does account for City wide increases during this time. Sheffield also has an increased population of students, which may have an impact on data. However, at this time a full breakdown is not available to access these specific impacts.

1.13 **Relevant Learning from NCISH relating to SHSC Strategy and Transformation**

Therapeutic Environments Programme

In relation to inpatient care, the importance of safer and more therapeutic environments is clearly emphasised by NCISH. This closely correlates with the work that SHSC is undertaking to modernise its estate, including the removal of ligature anchor points which has now been completed in the acute adult wards, meeting the requirements of CQC Section 29A.

The ward refurbishments have improved inpatient environments and provided de-escalation facilities to reduce the level of restrictive practice and seclusion as well as improving privacy and dignity.

The refurbishment of the Health Based Place of Safety provides a high-quality therapeutic space for patients who may be acutely unwell and in need of close supervision. The Decisions Unit provides a space for the assessment of patients in Crisis who would otherwise be assessed alongside patients with physical emergencies in A&E.

Clinical and Social Care Strategy

The NCISH identifies recognition of the importance of trauma as a key factor in reducing suicide. The SHSC Clinical and Social Care Strategy identifies suicide prevention as a central high-level objective. The fundamental principles of the Strategy are highly relevant to suicide prevention: Person-Centred and Trauma-Informed, Strengths-Based and Evidence-Led. Examples of this a self-harm suicide intervention workbook is being trialled on inpatient wards, a research programme is underway with liaison staff delivering harm reduction programmes and compassion focussed therapy for people who self-harm. The ROOTs and trauma informed training and emotional needs pathway have been taken forward across a number of services.

Clinical Observations and Leave policies

In relation to the NCISH observation that periods of leave from wards and discharges are high risk periods. SHSC has recently updated its Section 17 leave policy, including requirements around risk assessment and online training has been developed. Follow up within 72 hours of discharge is part of the acute care pathway, linked with the finding in NCISH that the immediate post-discharge period is a time of higher risk.

Primary Care and Community Care Transformation

The Primary and Community Transformation will enable more people who do not meet the criteria for secondary care. For example, it can be evidenced in Primary and Community Mental Health transformation by the work that is undertaken by teams to support traumatised people, including people who self-harm.

Sheffield Talking Treatments have developed an ethnically diverse outreach team to improve engagement and access to talking therapies in associate with VCSE and Faith leaders.

Learning Disability Transformation

The Sheffield Learning Disabilities Transformation will provide support to service users and families over an extended period, with particular focus on psychosocial interventions and the avoidance on inappropriate use of psychotropic medication (STOMP) to provide greater responsiveness, personalisation, a value-based

approach (Moulster and Griffiths nursing model) and increased use of positive behavioural support and enhanced Green Light working in mainstream services.

Inequalities

The use of an inequalities flag will improve recognition for people with inequalities and there is an active campaign being monitored to improve recording of protected characteristics. The focus on the importance of recognition of people with protected characteristics such as LGBTQ+ will enable factors affecting this community specifically to be identified and work with the LGBTQ Staff Network has enabled all staff members to become more familiar with asking about sexuality and sexual orientation. Inequalities and the need to adopt a data driven population health approach is a key feature of the Clinical and Social Care Strategy.

1.14 **Sources of Information: Suicide prevention strategy for England: 2023 to 2028**

Considerable progress has been made since the last Suicide prevention strategy for England was published in 2012. All areas of the country now have local suicide prevention plans and suicide bereavement services, supported by a £57 million investment through the NHS Long Term Plan.

Evidence shows one of the lowest ever suicide rates (in 2017) and collective efforts to improve patient safety led to a 35% fall in suicides in mental health inpatient settings in England between 2010 and 2020. However, while overall the current suicide rate is not significantly higher than in 2012, the rate is not falling.

1.15 **Overview of Strategy**

The strategy calls for collective effort across national government, the NHS, local government, the voluntary, community and social enterprise (VCSE) sectors, employers and individuals.

The overall ambitions set by this strategy are to:

- Reduce the suicide rate over the next 5 years – with initial reductions observed within half this time or sooner
- Improve support for people who have self-harmed
- Improve support for people bereaved by suicide
- Suicide prevention requires partnership working. The NCISH report highlights the risks of economic adversity, including loss of income and home. Although these are not directly within the influence of healthcare services, especially during an economic downturn, we can influence by working in partnership across Sheffield and South Yorkshire with colleagues in local authorities and VCSE. A specific example is reducing the risk of suicide associated with alcohol and substance misuse, which requires a range of measures from individual treatment through to education and public health interventions, e.g. licensing.

1.16 **Priorities for Action Over the Next 5 years**

Data, evidence and engagement with experts (including those with personal experience) has identified the following priority areas for action to achieve these aims. These are to:

- Improve data and evidence to ensure that effective, evidence-informed and timely interventions continue to be adapted
- Provide tailored, targeted support to priority groups, including those at higher risk. At a national level, this includes:
    - Children and young people
    - Middle-aged men
    - People who have self-harmed

    - People in contact with mental health services
    - People in contact with the justice system
    - Autistic people
    - Pregnant women and new mothers
- Address common risk factors linked to suicide at a population level by providing early intervention and tailored support. These are:
    - Physical illness
    - Financial difficulty and economic adversity
    - Gambling
    - Alcohol and drug misuse
    - Social isolation and loneliness
    - Domestic abuse
    - Neurodevelopmental disorders
- Promote online safety and responsible media content to reduce harms, improve support and signposting, and provide helpful messages about suicide and self-harm
- Provide effective crisis support across sectors for those who reach crisis point
- Reduce access to means and methods of suicide where this is appropriate and necessary as an intervention to prevent suicides
- Provide effective bereavement support to those affected by suicide
- Make suicide everybody's business so that we can maximise our collective impact and support to prevent suicides

1.17 **Key Quotes from the Strategy:**

"It is a way of updating our priorities, reflecting new evidence on who is at risk. The new strategy therefore highlights domestic violence, gambling, online safety and people on the margins of society because of poverty, ethnicity, disability or prejudice".

"The aim of this cross-government strategy is to bring everybody together around common priorities"

"Everyone should feel they have the confidence and skills to play their part in preventing suicides – not just those who work in mental health and/or suicide prevention directly – and take action to prevent suicides within and outside of health settings"

1.18 **SHSC Suicide Prevention Work**

SHSC suicide prevention strategy is guided by the national strategy; however the Sheffield strategy is set out regionally by the Sheffield City Council Suicide leads, with incorporated input from the South Yorkshire Integrated Care Boards (SY-ICB). It is the local strategy which influences SHSC strategy and development of training.

Suicide Awareness Training

The Suicide Awareness Training delivered within SHSC covers the areas within the national and local strategies from the 2012 strategy. However, it has incorporated information from a variety of sources over the period between conception and current training.

While the training is influenced by the strategy, data from the NCISH Annual Reports has been incorporated when released to reflect the ongoing updates, changes and new evidence presented. This allows the training to remain up to date and relevant, providing SHSC staff with the best available knowledge and evidence.

The training package is due for a review in 2024, in line with the new strategy and newly released NCISH data. However, the strategy has not identified any areas that were either not been addressed in the current training or suicide risk issues that

SHSC were not already aware of, meaning the training will only require minor updates to ensure it fulfils the objectives of the strategy.

Compliance within the Suicide Awareness Strategy was previously highlighted as a cause for concern by the CQC, however over the period of 2022 to 2023 intensive training schedules were implemented to ensure training targets could be achieved, with compliance moving from 18% in 2021/2022 to over 80% compliance from May/June 2023. This level of compliance is continuing to be maintained through regularly scheduled training dates.

Record Keeping Standards

The recent launch of the Record Keeping Standards training continues to strive for improvements in patient safety. The training incorporates elements of care planning, risk assessment, risk formulation, mitigation and safety planning. The training discusses consent and how we share information as an organisation, listening to families to improve safety, and to capture key information when thinking about demographics, risk, ethnicity and vulnerabilities.

1.19 Highlights for SHSC – How are we going to apply this within SHSC.

Many of the elements of the updated strategy reflect ongoing strategy from the 2012 work. Physical illness, middle aged men for instance are consistent well known risk factors that are already incorporated within SHSC strategy and training.

However, where the new strategy builds on the previous 2012 strategy there are some new key elements included which have a direct influence within SHSC, specifically:

- Autism
- Pregnant women and new mothers
- Gambling

1.20 Autistic People

Autistic people make up approximately 1% of the population but 11% of suicides, meaning autistic adults with no learning disability are 9 times more likely to die by suicide than the general population (RCPSYCH: Suicide and Autism, a National Crisis).

The NCISH study data reveals that 350 autistic people died by suicide between 2011 – 2021. This figure looked at the year-on-year data, and saw an increase from 13 suicides in 2011, increasing year on year to 61 in 2021. However, the evidence suggests that this is not an increase that has been seen due to other factors increasing suicide risk, moreso that the diagnosis and recognition of autism has increased during this time, reflecting more accurate reporting.

It is this message that has been key for SHSC in its planned response to address the new strategy, in that awareness and appropriate treatment of those with autism is key to the suicide prevention work we do. As well as the recently launched Oliver McGowan training within SHSC, specific elements of risks for autistic people will be incorporated within the Suicide Awareness Training, highlighting that autistic people are in a high-risk demographic.

Guidance from sources such as the Royal College of Psychiatrists suicide prevention workshops will also be utilised to discuss skills and strategies used in risk assessment and engagement with people with autism to provide support that is flexible, personalised and tailored to meet an autistic person's unique needs.

Additionally, as part of the response to the new strategy the Zero Suicide Alliance has recently launched an online training package developed with Greater

Manchester NHS Trust. The training is specifically focussed on autism and suicide awareness.

The training can be accessed through the online link, and will also be added to Jarvis and advertised for all SHSC staff to complete: (Autism and Suicide Awareness Training : Zero Suicide Alliance)

The information around the course from Zero Suicide Alliance states that:

The training has been co-produced with people from the autistic community and aims to:

- Share information about autism and suicide risk
- Share real experiences
- Coach you through spotting the signs and supporting an autistic person with four different scenarios (you can choose which ones you want to complete)
- Share resources for further support
  (Zero Suicide Alliance. 2024).

1.21 Pregnant women and new mothers

In the UK around one in five women experience a perinatal mental health problem during pregnancy or within the early postnatal years, with around 70% of those hiding or underplaying their illness. However, what is probably most shocking is suicide is the leading cause of direct maternal death within a year of giving birth.

There are many known risk factors that have been identified within the NCISH reports, Papyrus data and the Maternal Mental Health Alliance sources. These increased risk characteristics include:

- Existing mental health conditions
- History of suicidal thoughts or suicide attempts
- Substance abuse, including drug and alcohol abuse.
- Domestic violence and abuse.
- Lack of social support.
- Regular sleep disturbances.
- Past trauma

Again, these risk factors and the evidence base will be incorporated with the SHSC Suicide Awareness training.

1.22 Gambling

Gambling has become recognised as a key driver in suicidal ideation, and this has been termed gambling-related harms. Although the statistical data on gambling and suicide is in its early stages, the emerging evidence shows links between harmful gambling and suicide. NCISH has only recently begun to collect specific data with links in suicides to gambling, however there is enough supporting information for this to have made it into the new suicide prevention strategy.

Within the Suicide Awareness training at SHSC socio-economic factors are discussed within the training, and it is important to note that gambling links in with debt, financial issues and contributes to poor socio-economic outcomes, which can increase hopelessness and entrapment for instance.

For SHSC the information available will be incorporated into the Suicide Awareness training, with further information emerging from data added in when available.

All teams have been informed about the need to ask about gambling and refer on those with gambling issues. Particular attention has been paid to this in Sheffield Talking Therapies and Primary Mental Health Teams where people may present with gambling issues. A research project is due to start soon investigating the recognition of gambling in Primary Mental Health Teams.

1.23 Focus on work of Sheffield Talking Therapies

Staff in Sheffield Talking Therapies (STT) are an important group to be aware of the risk of suicide. A bespoke training has been developed for these staff which outlines the national priorities regarding suicide prevention.

The perinatal period is recognised to be particularly important - patients are assessed within 2 weeks and treatment commences within 4 weeks. The DNA policy is flexible for this population and staff routinely offer a further appointment to anyone on this pathway following a DNA due to increased vulnerabilities. There is a perinatal working group in the service that is looking to deliver CPD to enhance skills and knowledge needed to support people on this pathway and suicide risk/prevention will be included within this training.

A new senior Psychological Wellbeing Practitioner (PWP) will have protected time to work on the pathway in collaboration with Start for Life funded by Start for Life monies to promote a joined-up approach to working with people on this pathway. They will link with perinatal service, Start for Life, to increase knowledge of services to support people holistically. PWPs are also doing clinics in Family Hubs to make the service more accessible to people on this pathway.

STT also has a neurodiversity working group, older adults and working group to improve equality of access and outcomes for all. The equalities team delivers clinics in voluntary and community sector to increase visibility and presence including wider engagement work focussed on Men.

STT has a long-term conditions arm that works across 13 health conditions and the interplay between physical and mental health

STT is part of a national roll out of employment advisors to support people to stay in work and to gain employment. Recruitment is ongoing and will accelerate once funding from Department of Work and Pensions is confirmed on a recurrent basis.

STT have connected with the new gambling service and will refer patients on as needed. The gambling service lead (Leads and York trust) came to the PCMH whole team meeting in October 2024 ahead of the clinic opening in Sheffield. The team are aware of referral routes to the service and advise people as well as connecting with local run gamblers anonymous too

STT ask standards questions regarding Alcohol and drug misuse with referral and signposting as appropriate

Professional curiosity sessions have been held for profession specific teams and a joint action plan developed with safeguarding and STT to fulfil responsibilities in relation to domestic abuse.

1.24 Broader Approaches to Suicide Prevention Work – Interagency Working

At SHSC we adapt to the national and local strategies which inform and influence our suicide prevention work. However, we do not work in isolation. This summary will describe the coordinated and collaborative work with SHSC and partners to raise awareness of suicide prevention, share information, and seek to work across Sheffield to reduce suicide deaths.

1.25 Suicide Reference Group

The Suicide Reference Group is held bi-monthly and is chaired by the Clinical Risk and Safety Officer at SHSC. The group has membership from a variety of agencies

across Sheffield, and nationally who attend the group to discuss what work is going on locally and nationally.

SHSC engage with our local partners in this group to raise awareness, share information, discuss concerns/trends, and to come together as a group supporting those involved in suicide prevention. The attendees include (but are not exhaustive of):

- Sheffield City Council
- SACMHA
- Sheffield Flourish
- Papyrus
- Amparo
- Crisis House/Listening Ear
- Rethink
- Baton of Hope
- SHSC staff

1.26 **ICB Meetings**

Monthly South Yorkshire and national ICB Suicide Prevention meetings are attended where information is shared around strategies, new evidence, concerns or risks for instance. It is these meetings that wider information is shared, and learning can be shared from a variety of sources. Examples of those in attendance at the South Yorkshire ICB meetings includes:

- ICB
- Police
- British Transport Police
- Highways Agency
- South Yorkshire Ambulance Service
- Criminal Justice Agencies

These meetings can be integral to aiding SHSC strategy and information sharing, and much of what is discussed is shared with the wider audiences at Suicide Awareness training and at the Suicide Reference Group, for example. An example of this is around building work related to bridges, where remedial work was conducted by the Highways Agency to improve the safety on certain bridges where data was showing a 'hot-spot' for suicide. Work such as this and the sharing of information adds to the overall strategy and responsiveness within SHSC.

1.27 **Safety Plans**

There is a current piece of work led by SHSC, Sheffield City Council and Sheffield Flourish in the development of a Sheffield specific safety plan. There are many safety plans available online, mostly through charities or business ventures. While these are a useful resource, within Sheffield using a variety of safety plans can lead to reassessment of our services users, and an unfamiliarity with those who may be attempting to support those in need.

The Sheffield safety plan proposal is to have a safety plan for Sheffield, which includes Sheffield specific information for those living in Sheffield. The design of the plan has been developed, funding secured within Sheffield City Council budget, costing agreed with Hive (web designer) and agreement that the plan will be overseen by Sheffield Flourish through their website.

Access will be via the Sheffield Suicide Support and Prevention website, and the Sheffield Flourish website. When launched, SHSC will play a part in raising awareness of the resource through the above groups, through staff training, and through SHSC communication channels.

The safety plan will be available as an interactive form that can be saved and accessed by the service user only, but will also have sharing and printing capabilities built in. The safety plan will also be linked to the Sheffield Mental Health Guide resource, which is a comprehensive resource to all services available within Sheffield to support people (and includes Gambling, perinatal and autism support networks). This guide is again hosted through Sheffield Flourish, who is jointly commissioned by SHSC for these services.

SHSC will support Sheffield City Council and Sheffield Flourish to raise awareness of the safety plan, and part of this plan includes ensuring those in the community are aware of the safety plan and how to assist someone in completing the plan, and/or using the plan to seek support if the individual cannot.

1.28 **Real Time Surveillance**

In conjunction with the South Yorkshire Integrated Care Partnership, SHSC participates in a Real Time Surveillance system for intervention following suspected suicide. Suicide data from formal external routes, such as coronial inquests and national inquiries, is often subject to delays inherent in due process. In South Yorkshire, we have established a system facilitated by the Police where a death by suspected suicide is notified to involved partners in order that the bereaved can be appropriately supported (being bereaved through suicide is itself a risk factor for suicide) and that appropriate immediate investigation can be undertaken.

Between 2011 and 2021, there were 3,894 patients who died by suicide in a public place, 29% of all patient suicides, and an average of 354 deaths per year. They appeared to be more acutely unwell (with higher rates of schizophrenia and other delusional disorders) and self-harm, drug misuse, relationship break-up and financial problems were more common. Real Time Surveillance works to collate evidence around suicide in public places and addresses potential ways to reduce this with the local area authorities.

1.29 **Partner Organisations**

Our partner organisations within Sheffield work with us through our ongoing connections and through the suicide reference group. Below is some information around the work in the community with some of our close partner organisations.

Amparo

Amparo is a bereavement service that operates nationally but has branches throughout the UK. Amparo South Yorkshire is a free and confidential service commissioned by Local Authority, Public Health and NHS services in Barnsley, Doncaster, Rotherham and Sheffield to offer free bereavement support across Sheffield, and it is Amparo SHSC signposts for bereavement support. Amparo also offers bereavement support for professionals facing bereavement in their work roles, and this is discussed within the Suicide Awareness Training offer.

SACMHA

SACMHA is a charitable organisation established in 1988 in response to the health and social care needs of people of African and Caribbean descent. SACMHA staff and leaders work closely with SHSC supporting and adding to the improvement of mental services across the board.

SACMHA offers a range of mental health support, including:

- Counselling Referral Service
- Carers Support Service
- Hospital Advocacy
- Hospital In-Reach Service

- Community Support
- Black Men's Group
- Call & Chat Service
- Social Café

SACMHA also champion support in the community around suicide awareness such as The Black Male Barbers Mental Health Project, with its aim is to work with local barbers to develop their knowledge and understanding of mental health related to Black men.

Sheffield Flourish

Sheffield Flourish is a charity that works collaboratively on innovative digital and community projects, recognising the untapped strengths of people who've experienced mental health challenges. Sheffield Flourish and SHSC work together to support a variety of projects across Sheffield, in collaboration with Sheffield City Council.

The recent development of the Sheffield Safety Plan was a collaboration between the three organisations, with Sheffield Flourish leading on the digital development with Hive Digital, a small Sheffield based company who have designed the digital platform for the safety plan.

Sheffield Flourish have a large digital resource available to support those experiencing mental health issues, and their websites include The Sheffield Mental Health Guide, My Toolkit, and Sheffield Suicide Support and Prevention website.

The Sheffield Mental Health Guide is a web-based A-Z of services available in Sheffield (Nationally available services also listed). These services are listed in an easy to access format to allow people to find what support is available for them. This includes services such as gambling addiction, domestic abuse, sexual addiction, drug and alcohol services, counselling support for example.

The Sheffield Suicide Support and Prevention website is a joint website funded by Sheffield City Council's suicide strategy, hosted by Sheffield Flourish. The website focusses on suicide prevention, bereavement, and is linked in with the local and national suicide strategy.

Listening Ear

Listening Ear is a charitable organisation that has a focus on support through counselling and work to help those who've been bereaved, suffered loss or experienced separation. Listening Ear offer specific counselling and support, including age-appropriate bereavement therapy services for children and young people.

Section 2: Risks

2.1 The primary risk is of patient harm due to ineffective approaches to suicide prevention. This report describes a range of work that is underway. The risks relate to the diversity of work from estates to service transformation, and risks related to partnership working. The mitigation of the risk is captured in relation to each specific piece of work. The overarching risk is of not capturing and synthesising progress with accurate data, including within SHSC's major change programmes.

2.2 Resources – the NCISH report and the Suicide prevention strategy for England: 2023 to 2028, describe aspirational targets. However, many of these targets are around everyone feeling 'they have the confidence and skills to play their part in preventing suicides'. While this is an obvious area of upskilling, it is also ambitious in its scope without providing any specific resources or financial additions to provide training/education. This does not fall within the remit specific to SHSC though, and the continued SHSC focus is the Suicide Awareness Training.

2.3 Maintaining compliance – the Suicide Awareness Training compliance is a requirement of the CQC for all practitioners who undertake formal clinical risk assessments and is essential to ensure training compliance is maintained.

Section 3: Assurance

Benchmarking

3.1 Current benchmarking, including the need for further development, is contained within the body of the report.

3.2 Progress with Suicide Awareness work can be triangulated with a range of patient safety measures including incidents, complaints, training, and supervision.

3.3 SHSC's prevention and training has been aligned with CQC requirements and local and national policies.

Triangulation

3.4 Regular audit and monitoring of training compliance, review and learning outcomes from related incidents, National Patient Safety Alerts, partnership

working with other NHS and statutory organisations to share information, National Confidential Inquiry into Suicide in Mental Health (NCISH) reporting.

Engagement

3.5 SHSC's suicide prevention training has been co-designed with experts by experience. As the visibility of suicide prevention in SHSC increases, we will work to co-design and co-produce all aspects of the approach. This is an area for further development.

Staff engagement has been assured through sharing of information (Policy, Blue Light Alerts), Incident reporting and training (including Suicide Awareness Training, Basic/Intermediate Life Support Training, Ward and area specific inductions, heat map usage, safety huddles).

Section 4: Implications

Strategic Priorities and Board Assurance Framework

1. Recover services and improve efficiency.
2. Continuous quality improvement.
3. Transformation - Changing things that will make a difference.
4. Partnerships – Working together to have a bigger impact.

4.1 Improve efficiency – By ensuring all best evidence-based practice information is available, accessible and adhered to by SHSC staff, allowing for good clinical risk assessments and suicide prevention strategies to be used to support our services users.

Continuous quality improvement through adherence to local and national guidelines and standards in relation to patient safety. Quality improvement for service users by providing a safer environment and mitigation of known risks.

Transformation – as part of our evidence-based approach in using the most up to date data from sources such as NCISH, Realtime Surveillance, National Patient Safety Alerts/Blue Light Alerts, SHSC can continue to transform and adapt the training and guidance provided to staff to support our service users.

Partnerships – working collaboratively across SHSC areas, and with partner agencies both locally and nationally to share data, innovations and risk, to ensure that the risk mitigation and continuous service improvement initiatives are both shared with SHSC, and that SHSC shares this information with our partners, stakeholders and commissioners.

Equalities, diversity and inclusion

4.2 Suicide prevention is a key component of reducing inequalities because people with a range of protected characteristics are at increased risk of death by suicide.

Culture and People

4.3 Suicide prevention has training implications including risk assessment, safety planning, person-centred care and trauma-informed care.

Integration and system thinking

4.4 Suicide prevention is a place and system priority.

Financial

4.5 The explicit financial impacts are not considered in this paper but relate to the financial aspects of the range of work being undertaken that has an impact on suicide prevention.

Compliance - Legal/Regulatory

4.6 Relevant law includes Human Rights Act 1998, Health and Social Care Act 2012 and Mental Health Act 1983.

Environmental sustainability

4.7 Evidence-led care for suicide prevention is more sustainable because it avoids inappropriate medicines, advocates for a considered approach to inpatient care and relies upon person-centred care that is integrated within communities.

Section 5: List of Appendices

Appendix A:
Annual report 2024: UK patient and general population data 2011-2021
https://sites.manchester.ac.uk/ncish/reports/annual-report-2024/

Appendix B:
Suicide prevention in England: 5-year cross-sector strategy
https://www.gov.uk/government/publications/suicide-prevention-strategy-for-england-2023-to-2028/suicide-prevention-in-england-5-year-cross-sector-strategy

Appendix C:
Home | Maternal Mental Health Alliance

Appendix D:
https://www.rcpsych.ac.uk/docs/default-source/improving-care/nccmh/suicide-prevention/workshops-(wave-4)/wave-4-workshop-2/suicide-and-autism---slides.pdf?sfvrsn=bf3e0113_2

Appendix E:
New analysis shows problem gamblers are more likely than others to have suicidal thoughts, attempt suicide and to harm themselves (gamblingcommission.gov.uk)

Appendix F:
The Link Between Maternal Mental Health & Suicide Risk | Papyrus (papyrus-uk.org)

Appendix G:
South Yorkshire - Amparo

Appendix H:
About SACMHA

Appendix I:
Home | Sheffield Flourish mental health charity and supportive community

Appendix J:
About us - Listening Ear Merseyside (listening-ear.co.uk)