TOWARDS ZERO SUICIDE

A SUICIDE PREVENTION NETWORK ACTION PLAN (draft version 8)

for

London Borough of Hammersmith & Fulham,

Royal Borough of Kensington and Chelsea,

City of Westminster

2018-2021

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Foreword

My annual report for 2016/2017 focused on the importance of protecting and improving our own mental wellbeing, and that of the people around us – our families, friends, neighbours, and local community.

Good mental wellbeing is important for us to lead happy, healthy lives. It is often defined as 'feeling good' and 'functioning well' – so is not only about feeling happy or content, but also about how we cope and engage in the world around us.

The costs of suicide to families and wider society are significant. A conservative estimate is that for every person who dies at least 10 people are directly affected. The economic cost of each death by suicide of someone of working age is estimated to be £1.67 million. This covers the direct costs of care, indirect costs relating to loss of productivity and earnings, and the intangible costs associated with pain, grief and suffering.

At the consultation event held in November 2017 for this suicide prevention action plan, Sarah Anderson from the Listening Place summed up the challenge we have before us as follows:

"People who die by suicide don't want to die, they just cannot bear the idea of continuing to live feeling the way they do."

There is good evidence to show that suicide is preventable. It will require the combined efforts of health and social care, voluntary and private sector organisations which are detailed in this plan. But it will also require the mobilisation of families, friends, neighbours and local community so that each and every one of us feel valued and supported in both the good and bad times of our lives.

Dr Mike Robinson
Director of Public Health

1.0 Background

Every day in England around 13 people take their own lives. The effects can reach into every community and have a devastating impact on families, friends, colleagues and others. Each one of these deaths is a tragedy. Preventing suicide requires the combined actions by local authorities, mental health and health care services, primary care, community based organisations and voluntary agencies, employers, schools, colleges and universities, the police, transport services, prisons and others.

Local Authorities are well placed to prevent suicide because their work on public health addresses many of the risk factors, such as alcohol and drug misuse, and spans efforts to address wider determinants of health such as employment and housing. There are also important and varied opportunities to reach local people who are not in contact with health services through on-line initiatives or working with the third sector. To this end Hammersmith & Fulham, Kensington and Chelsea, City of Westminster councils commit to coordinating the suicide prevention strategy in their boroughs and in particular building the partnership of organisations to work together on this important agenda. Accountability for the suicide prevention strategy and its associated action plan lies with the health and wellbeing boards of the respective boroughs.

The first suicide prevention action plan for Hammersmith & Fulham, Kensington and Chelsea, City of Westminster was published in 2013. This second suicide prevention action plan seeks to build on the progress made so far. Work to prevent suicide in the three boroughs is co-dependant on existing and developing work to promote good mental health, in particular amongst men, young people and minorities. The last Annual Report from the Director of Public Health took mental health as its focus. A key recommendation from that report was the production of a mental health JSNA and subsequently the development of a mental health strategy. The actions from the mental health strategy will deliver the wider work to achieve of effective, long term, upstream suicide prevention, which are outside the scope of this action plan.

Both this action plan and the future mental health strategy will seek to capitalise on Thrive LDN which is supported by the Mayor of London. It strives for London to be:

1. A city where individuals and communities are in the lead
2. A city free from mental health stigma and discrimination
3. A city that maximizes the potential of children and young people
4. A city with a happy, healthy and productive workforce
5. A city with services that are there when and where needed
6. A zero suicide city

2.0 How this Action Plan has been Developed

The production of this action plan has been overseen by the multi-agency Suicide Prevention Working Group which has representation from mental health trusts, the local authority public health department, third sector and the CCGs. Its development has been informed by the Public Health England guidance, Local Suicide Prevention Planning-a practice resource, Oct 2016 and through two local multi-agency discussions, one held in January 2017 and one held in November 2017. A working draft is being presented to the Health and Wellbeing Boards for their comment and steer with the intention of bringing a final document back for ratification in May 2018.

3.0 10 things that everyone needs to know about suicide prevention[1]

The effects of suicide can reach into every community and have a devastating impact on families, friends, colleagues and others.

1. Suicides take a high toll

There were 4,575 deaths from suicide registered in England in 2016 and for every person who dies at least 10 people are directly affected.

2. There are specific groups of people at higher risk of suicide

Three in four deaths by suicide are by men. The highest suicide rate in England is among men aged 45-49. People in the lowest socio-economic group and living in the most deprived geographical areas are 10 times more at risk of suicide than those in the highest socio-economic areas group living in the most affluent areas.

3. There are specific factors that increase the risk of suicide

The strongest identified predictor of suicide is previous episodes of self-harm. Mental ill-health and substance misuse also contributes to many suicides. Suicide prevention strategies must consider and link to programmes of early identification and effective management of self-harm, mental ill-health and substance misuse.

4. Preventing suicide is achievable

The delivery of a comprehensive strategy is effective in reducing deaths by suicide through combining a range of integrated interventions that build community resilience and target groups of people at heightened risk of suicide. Directors of public health and health and wellbeing boards have a central role. Their involvement is crucial in co-ordinating local suicide prevention efforts and making sure every area has a strategy in place.

5 Suicide is everybody's business

A whole system approach is required, with local government, primary care, health and criminal justice services, voluntary organisations and local people affected by suicide having a role to play. Suicide prevention can also be part of work addressing the wider determinants of health and wellbeing.

[1] Local Suicide Prevention Planning-a practice resource, Oct 2016, PHE

6. Restricting access to the means for suicide works

This is one of the most evidenced aspects of suicide prevention and can include physical restriction, as well as improving opportunities for intervention.

7. Supporting people bereaved by suicide is an important component of suicide prevention strategies.

Compared with people bereaved through other causes, individuals bereaved by suicide have an increased risk of suicide and suicidal ideation, depression, psychiatric admission as well as poor social functioning.

8. Responsible media reporting is critical

Research shows that inappropriate reporting of suicide may lead to imitative or copycat behaviour.

9. The social and economic cost of suicide is substantial and adds to the case for suicide prevention work.

The economic cost of each death by suicide of someone of working aged is estimated to be £1.67million. This covers the direct costs of care, indirect costs relating to loss of productivity and earnings and the intangible costs associated with pain, grief and suffering.

10. Local suicide prevention strategies must be informed by evidence

Local government should consider the national evidence alongside local data and information to ensure local needs are addressed.

4.0 2013-18 Suicide Prevention Progress Review

This suicide prevention network action plan builds on the action plan from the 2013-18 suicide prevention strategy which had four overarching goals:

- Timely communication and information sharing between agencies on identification of at risk individuals and care pathways.
- Public education and awareness of suicide and/ or mental health promotion through community outreach, anti-stigma campaigns etc.
- Promotion of existing suicide prevention resources, interventions and support services e.g. the Maytree Respite Centre, telephone helplines operated by the Samaritans or Campaign Against Living Miserably (CALM)
- Priority training for frontline workers (GPs, A&E and concerned others) through programmes like mental health first aid or applied suicide intervention skills training.

Highlights of progress against the 2013-18 action plan are detailed below and include training from front line workers, mental health trusts developing their own action plans and the completion of a coroner's audit. Challenges have included information sharing about services. Though a service mapping was conducted it was not published as planned on a website due to lack of resource. Engagement with employers to raise the issue of mental health and suicide was also attempted but was not successful and it was decided that a better vehicle would be the Healthy Workplace Charter.

Highlights from Multi-agencies

NWL Collaborative of Clinical Commissioning Group's Training programme

Suicide awareness training and suicide intervention training was commissioned by Central London Clinical Commissioning Group on behalf of the three boroughs. The first year was paid for by Central London Clinical Commissioning Group, the second year by Hammersmith and Fulham Clinical Commissioning Group.

There were two face-to-face courses for clinicians and front line staff – one 'lite' half day course and a more comprehensive full day course.

A train the trainer course has been run in 2017 to train GPs to provide suicide intervention training in the future. In addition, an eLearning course has also been commissioned with 700 places available. This will be rolled out in the near future for GPs, their front line staff and voluntary sector workers.

The training delivered so far has been found to be successful in reaching out to all sectors. Therefore, in the action plan it is recommended that it continues alongside the Like Minded Mental Health Awareness training, particularly to community groups/members in the North Kensington area.

Public Health Commissioned Suicide Prevention

The Local Authority Public Health department currently commissions the Campaign Against Living Miserably (CALM): a service targeting men at risk of suicide which provides a telephone helpline and social marketing techniques to raise awareness of depression.

Coroner's Audit

A suicide audit of coroner's data was completed by Public Health in 2014 to improve our understanding of the population characteristics and circumstances of the cohort to improve targeting of prevention work. Findings from that audit are in included in section 5.

Children and young people

The Three Borough Local Safeguarding Children's Board completed a Task and Finish Group on preventing suicide with children and young people, by educating schools on the pathways and referral mechanisms and this was then included in the LSCB training programme.

British Transport Police (BTP)

The BTP published a new strategy "From Crisis to Care, A Strategy for Supporting People in Mental Health Crisis and Prevention Suicide on the Railway 2016-2019". It has 7 theme areas for action;

1. Data and analysis
2. Upstream prevention
3. Restricting access to means
4. Safeguarding and crisis care
5. Managing the consequences
6. Tackling suicide contagion
7. Enabling and education

The strategy recognises that the police have a role to play in responding to people in crisis and in referring vulnerable people to support services. The police also have responsibility to support local authorities in their multi-agency work to manage the risk of suicide, by dealing with threats, attempts and completed acts of suicide, and standardising their approach to the recording, management and sharing of data so that communities can be protected.

Metropolitan Police

The Metropolitan Police have focused on improving care whilst individuals are in custody firstly through comprehensive risk assessments for all detainees, by the custody sergeant and secondly ensuring access to mental and physical health care professionals in custody suites. The Metropolitan Police are implementing Dedicated Mental Health Liaison officers

in each area; working to highlight Protecting Vulnerable People (PVP) vulnerabilities with a view to partnership resolution; and working closer with BTP to assist suicide prevention.

Central & North West London NHS Foundation Trust and West London Mental Health Trust

The Central & North West London NHS Foundation Trust and West London Mental Health Trust made the progress against the four overarching goals of the 2013-18 Suicide Prevention Strategy. In addition, they worked on a fifth goal on targeted interventions for at risk groups.

Goal One: Timely communication and information sharing between agencies on identification of at risk individuals and care pathways

- All known Mental Health patients with acute or severe and enduring mental health problems (and their carers), who are at high-risk of self-harm or suicide, have their care co-ordinated through the Care Programme Approach

- A member of the clinical team completes a follow up contact within 7 days of discharge from acute mental health admission wards

- Home Treatment Teams have capacity to effectively follow-up high-risk patients discharged from acute mental health services in their homes.

- Both trusts have introduced the Single Point of Access and CNWL have Rapid Response Teams available 24 hours a day to assess and support those who have been referred by the Single Point of Access (SPA)

- Treatment plans include psycho-social interventions where appropriate, to comply with NICE Guidance.

- Teams follow the Care Act with a person-centred approach which has a recovery focus, so that the individual needs are met and collaborative working to ensure involved in decision making over care plans and safety planning. Families/carers are involved where possible as this supports safer care.

Goal 3: Promotion of existing suicide prevention resources, interventions or support services

Ligature risk assessments are now expected as part of inpatient mental wards and every ward have a Ligature Risk Management Plan. These are audited and as additional risks are identified these are mitigated and plans to address where possible. It is not possible to remove every risk, so staff have to understand how to manage the risks to low. These Ligature Risk Plans are reviewed in CQC inspections.

Goal 4: Training for frontline workers through programmes

Connecting with People is an evidence-based training package for all organisations working with people who are at risk of suicide. CNWL have trained 8 staff and are licensed to train other staff in the Trust over the next 3 years.

The Clinical Risk Training which is mandatory at WLMHT has been revised to enhance the focus on the assessment and management of suicide risk and guidance of use of clinical formulation

Goal 5: Targeted interventions for at risk groups (bereaved families, people from BME background, people with mental health issues, people known to mental health services, etc.).

- Risk training highlights the high risk groups identified in the National Confidential Inquiry (October 2016) e.g. men in middle age, LGBT who have recently migrated to this country in the last 5 years, recent moves from local geographical area, older adults and those who live alone – and the need to improve social support to reduce social isolation.

- Crisis plan, cards and relapse signatures are developed /completed with the service user so that they develop a safety plan and identify signs that can be highlighted to families/services should they become unwell and contact numbers for services.

- If a suicide occurs, In CNWL, a Family Liaison Officer is appointed to link with the family while the incident is investigated and to support them gaining access to relevant services. We offer support for bereaved families through Psychology Services, if required. In WLMHT, a clinician is appointed to liaise with and support the family, during the investigation and both trusts facilitate contact with CRUSE and would continue to support families after the event on an individual basis.

Multi-agency Suicide Prevention Working Group

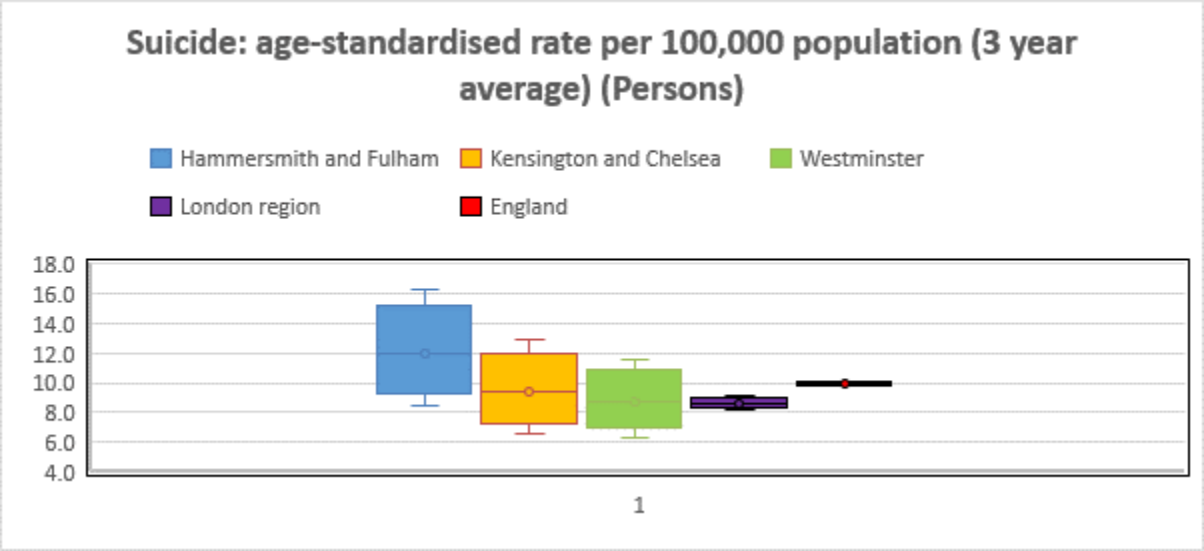
Since 2011 when the need for a multiagency approach and the development of a suicide prevention strategy was identified, Public Health established, lead and co-ordinated a multi-stakeholder Suicide Prevention Working Group across the three boroughs. This group had membership from voluntary sector, CCGs, the local authorities, mental health trusts and the Metropolitan and British Transport Police. Leadership of the group transferred to the CCGs in 2013. After an interregnum the group was reconvened in July 2017 by Public Health and it has met regularly to steer the production of this new action plan. The working group has no resources allocated to it at present.

5.0 The Local Need for Suicide Prevention Multiagency Plan

Suicide has a devastating social, emotional and economic impact and is a leading cause of years of life lost. A person who commits suicide in London typically loses 23 years of their life. For the Hammersmith and Fulham this is 28.2 years, Kensington and Chelsea 28.3 years, Westminster 25.5 years (source: Public Health England Suicide Prevention Profile[2]). This report gives an update on the latest suicide data published by the Office for National Statistics and Public Health England. It compares local suicide rates to the London and national average, reports on trends over time and compares suicide rates by age and sex.

In 2016 there were 12 suicides in Hammersmith and Fulham, 10 in Kensington and Chelsea and 10 in Westminster. The rates for Kensington and Chelsea and Westminster are similar to the London average. Rates in Hammersmith and Fulham are higher than the average for London (see Figure 1), but are not significant due to the small number of deaths. The suicide rate in Hammersmith and Fulham has been consistently higher than the London average over the last 14 years (see Figure 2).

Figure 1 Age standardised suicide rates, three year aggregate 2014-2016



Hammersmith and Fulham: 11.9 (95% confidence interval 8.4-16.3); Kensington and Chelsea: 9.3 (6.5-12.9); Westminster: 8.7 (6.3-11.6); London 8.7 (8.2-9.1); England: 9.9 (10.1-9.8)
Source: Office for National Statistics, Suicides in England and Wales by local authority, 2002 to 2016

The London suicide rate is significantly lower than the England average. While previously the suicide rate showed a downward trend in London (see Figure 2), in 2015 the number of suicides increased by 33% to 735 compared to 552 in 2014 (This is not seen on Figure 2 as this is graph shows a three year rolling average.) But the confidence intervals overlap so this may be due to chance. There has been no significant change over time in the suicide rates

[2] https://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide

for Hammersmith and Fulham, Kensington and Chelsea and Westminster as numbers are relatively small.

The following groups are at higher risk of death by suicide: men (15 to 59 years), looked after children, older people, black and minority ethnic communities, people with previous suicide attempts and people in crisis (for example bereaved by suicide, relationship breakdown, loss of employment). For further information, go to the JSNA. https://www.jsna.info/document/suicide-prevention.

Figure 2 Trend in age standardised suicide rates, three year aggregates 2001-2003 to 2013-2015

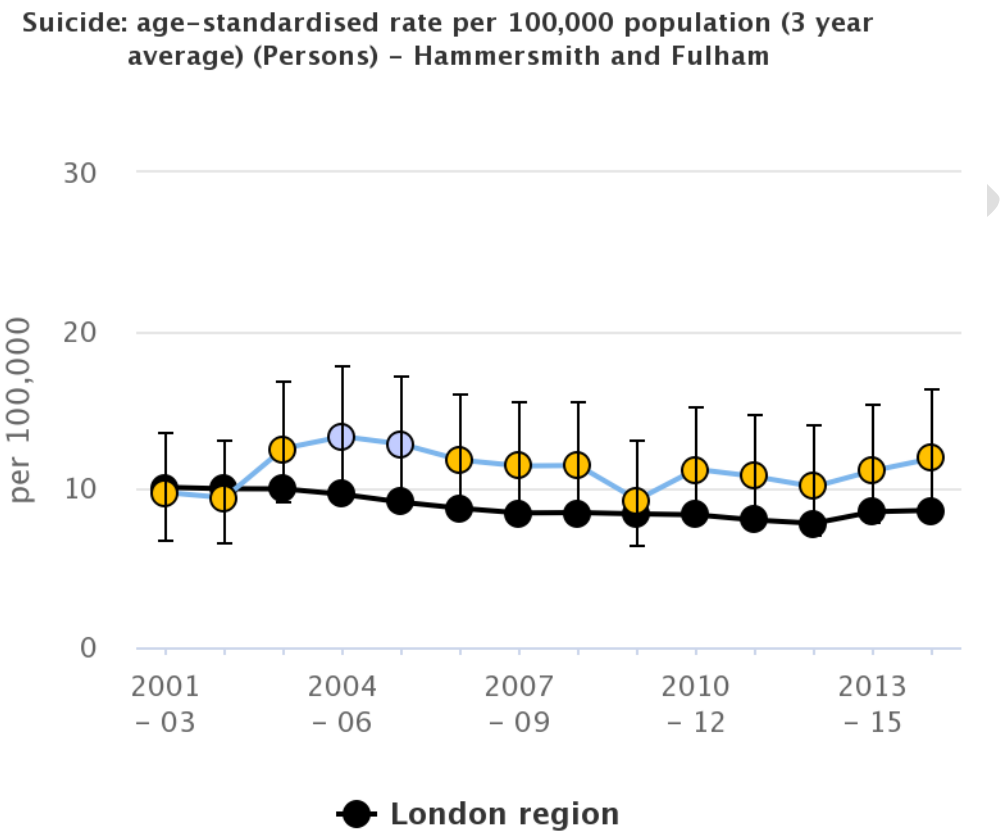
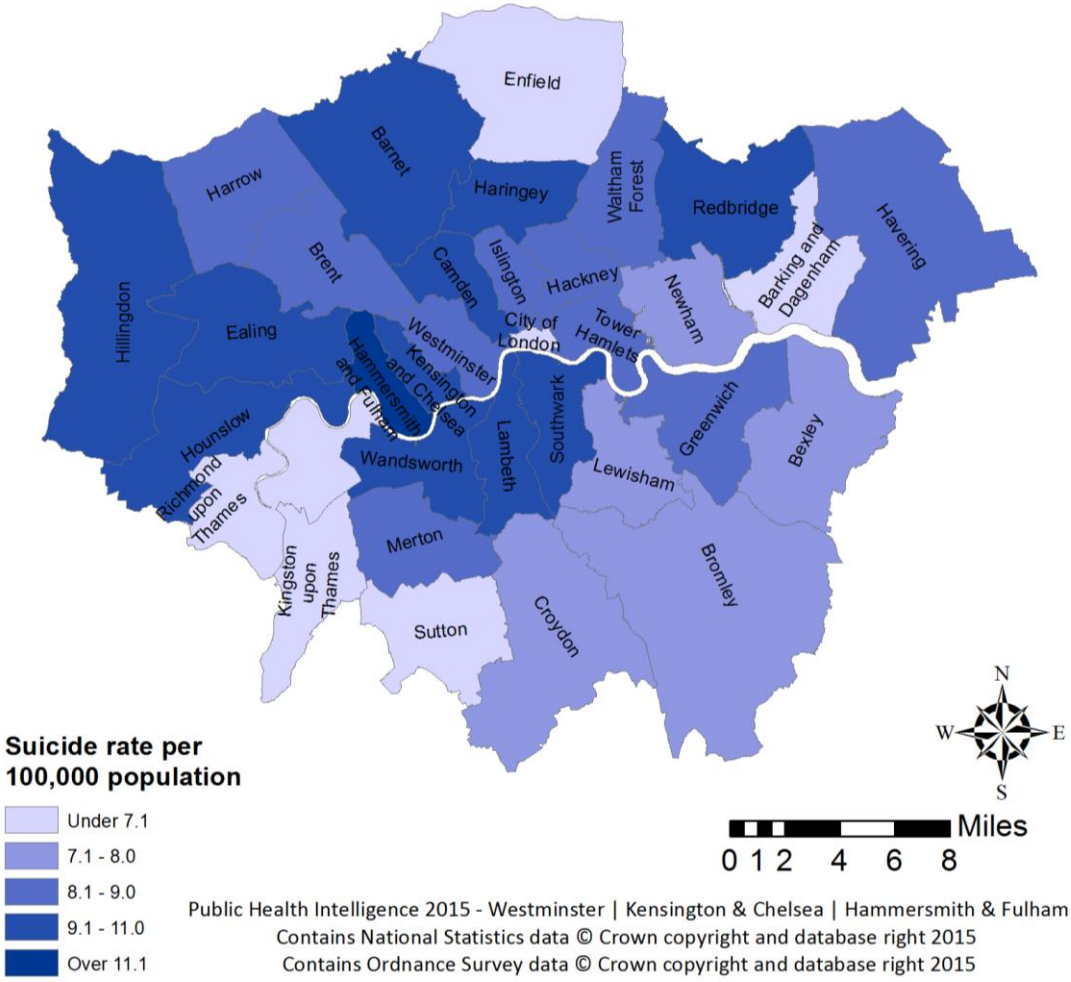


Figure 3 Variation in suicide rates among London Boroughs, three-year aggregate age-standardised rates 2014-2016



Note: none of the differences shown above are statistically significant

Source: taken from the London Assembly Health Committee data from the Office for National Statistics

Coroner's Audit Findings

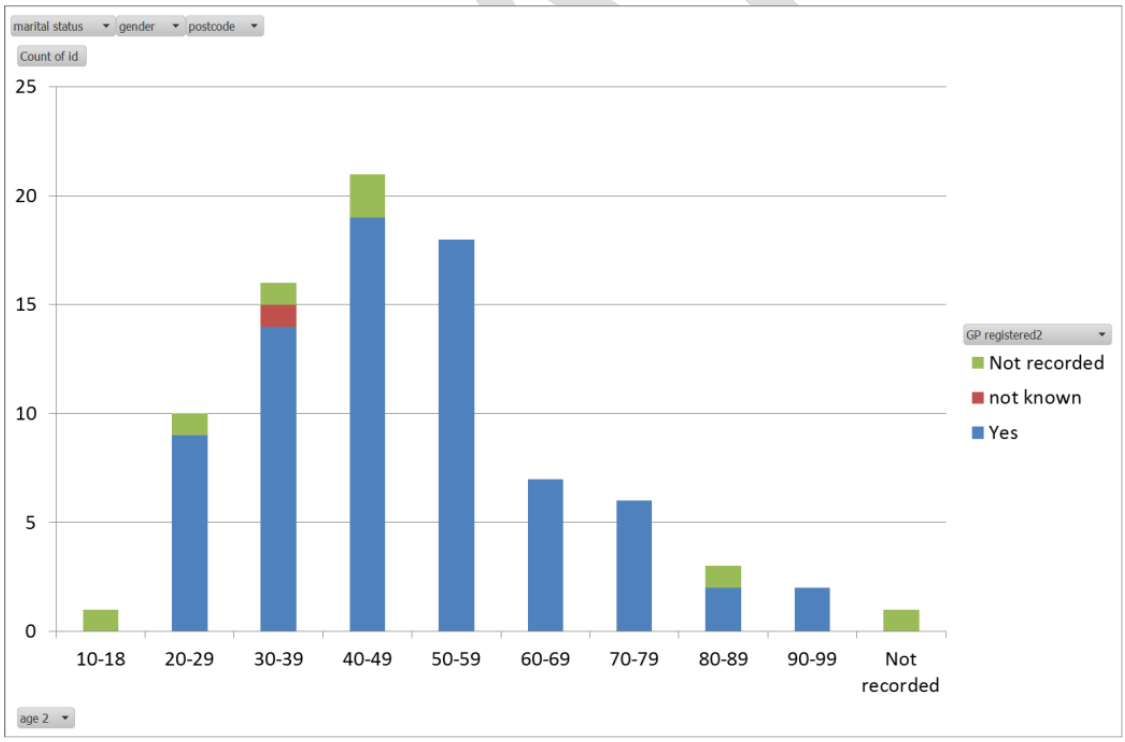
A suicide audit of coroner's data was completed by Public Health in 2014. The audit highlighted that the majority of deaths from suicides locally was attributable to men: 55 of the 85, with the majority being aged between 30-60 years of age. 95% of people who completed suicide were registered with a GP, showing that most deaths occurred amongst the registered resident population.

Though there is a high proportion of BME community groups in acute mental health services suicide rates are low. The breakdown of death by suicide according to ethnicity in the audit was Ethnicity Caucasian/White (78%) followed by Asian and Other (8%), mixed at 2% and black at 1%.

In general White, single, middle aged men; white, single, younger, females and white, married, middle aged women formed the majority of people who died by suicide.

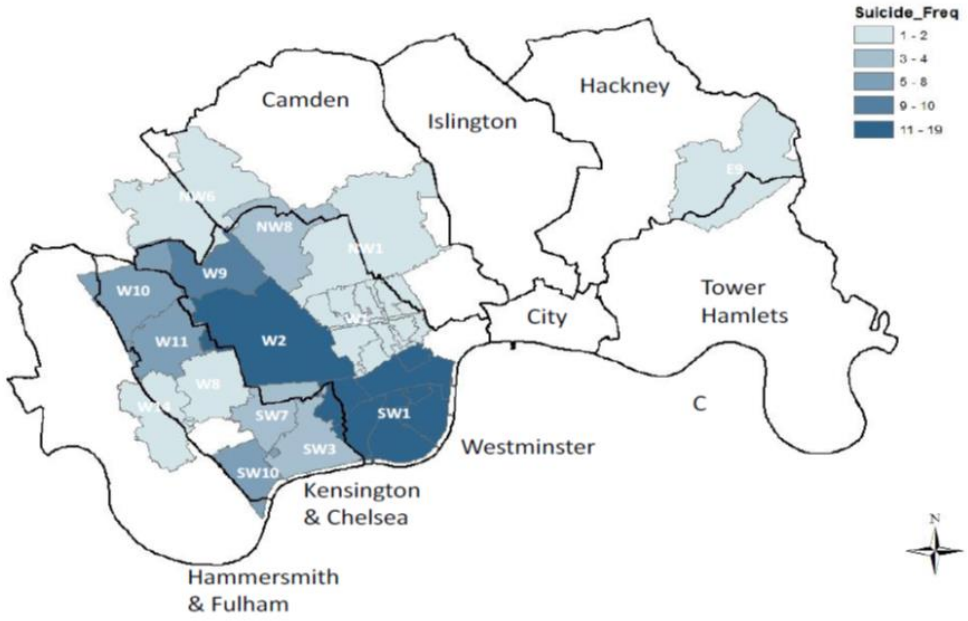
The audit has shown a high prevalence of suicides (83%) occurring at home, with a number of these known to housing services. Likewise, W2 and SW1 feature predominantly in complete suicide cases. However, these are small numbers.

Figure 5 Deaths by age and GP registration in Inner North West London



Source: Coroners Audit of Suicides in Inner North West London, 2014

Figure 6 Suicides Inner North West London Coroner – place of death mapped by postcode



Source: Coroners Audit of Suicides in Inner North West London, 2014

British Transport Police

The British Transport Police (BTP) collect data on suspected suicides, injurious attempts, and pre-suicidal/mental health incidents that have occurred on BTP jurisdiction. The data below is from the National Suicide, Pre-suicide and Mental Health Profile August 2017.

Figure 7 The number of pre-suicidal/mental health incidents, lifesaving interventions, s136[3] detentions and S136 detentions made by British Transport Police in 2016/17

	Pre Suicidal/Mental Health Incidents	Life-Saving Interventions	S136 Detentions	S136 Detentions (BTP)
Hammersmith and Fulham	45	10	16	12
Kensington and Chelsea	35	8	7	7
Westminster	278	33	126	111

When looking at the number of suspected suicides and injurious attempts per 100,000 of the population, the majority of areas with the highest rates tend to be in London (Camden, Westminster and Kingston upon Thames). With respect to the time of year, peaks were seen in April and October, whilst drop were seen in February and June. The largest proportion of incidents occurred on Monday, with fewer incidents occurring at the weekend. The largest

[3] Section 136 is part of the Mental Health Act. The police can use Section 136 to take a person to a place of safety if they think they have a mental illness and need care or control

proportion occurred in the morning period between 10.00 and 12.00 or in the evening period between 17.00 and 19.00. The most common risk factors for suicide on the railway include: a history of mental health issues (60.5%), alcohol and /or drug abuse (18.4%), relationship issues (10.7%) and family issues (7.5%).

London Underground has seen a notable increase in the number of suspected suicides over the past three years and is disproportionate to the rise in the total population of London. Part of this rising trend on London Underground relates to an increase in individuals under the age of 30. 2015/16 saw 15 individuals in suspected suicides or injurious attempts under the age of 30 whilst 2016/17 saw 25.

Summary

The data we currently have available indicates that there has been no significant decrease over time in the suicide rates for Hammersmith and Fulham, Kensington and Chelsea and Westminster. Therefore, the need for multi-agency action on prevention appears to be as great as ever. Men continue to make up the vast majority of those who die by suicide in the three boroughs. Therefore, the action plan includes priority focus on men. The rise is suspected suicides and injurious attempts in under 30 in London Underground is an area of concern and requires monitoring and investigation.

5.0 Priorities for the strategy

The priorities for the action for 2018 -2021 seek to build on the progress that has been undertaken to date, ensure that those gains are held and concentrate efforts on a limited number of achievable areas. Tackling suicide prevention will be an iterative process over the long term across many settings. Action will also be taking place on a number of levels, working with partners at London Region, at North West London and at borough level. Priority setting has been informed by local data, national guidance and through discussion in the Suicide Prevention Working Group and with the wider suicide prevention partnership of organisations including at a consultation event held on 7th November 2017.

The three borough level priorities areas for 2018-2021 are:

- Reducing risk in high-risk groups
- Tailoring approaches to improve mental health in specific groups
- Provide better information and support to those bereaved or affected by suicide
- Promotion of a multiagency approach

The North West London sub-regional priority area for 2018-21 is:

- Improving data collection and monitoring

The London Regional level priority area for 2018-21 is:

- Supporting the media in delivering sensitive approaches to suicide and suicidal behaviour

Indicators for Success

Indicators for success
-10% annual reduction in the overall suicide rate - At least 10% reduction in male suicide rate - Reduction in recorded attempted suicides - Reduction in self-harm (A&E attendances and hospital admissions)
Process Indicators
- Resources identified for delivery and oversight of Suicide Prevention Plan by March 2019 - Action plan agreed and signed off by the Hammersmith & Fulham, Kensington and Chelsea and City of Westminster Health and Wellbeing Boards by May 2018

Multi-agency Suicide Prevention Working Group

The Director of Public Health is the lead for suicide prevention in the Local Authority. He has established a suicide prevention working group. This is a multi-agency group that meets quarterly. A range of agencies operating in the area that have a strategic interest in promoting mental wellbeing are invited to the meeting. These include local NHS mental health trusts, London Underground, NHS acute trusts, local authority, public health, police (British Transport and Metropolitan), clinical commissioning groups, academic institutions, community providers. The working group also plans to include representation from families bereaved by suicide.

The group seeks to promote effective inter-agency working in communicating, managing and preventing suicide incidents in the three boroughs. The group will also take responsibility for monitoring the progress of the implementation of the Suicide Prevention Action Plan and report to the Health and Wellbeing Boards of the respective boroughs who are responsible for the strategy on an annual basis.

Links to the wider health and wellbeing agenda

Suicide is a complex issue and this prevention strategy recognises the importance of tackling factors that can lead to suicide in order to be most effective. With this in mind suicide prevention will need to be incorporated in other key strategies including:

- Mental Health JSNA
- Mental health and wellbeing strategies
- Sustainability and transformation plans
- Local transformation plans for children and young people's mental health and wellbeing
- Commissioning of alcohol and substance misuse service
- Commissioning of the adult mental health service and Child and Adolescent Mental Health Services (CAMHS)
- Adult social care commissioning
- Crisis Care Concordat action plan

A Suicide Prevention Plan for the population affected by the Grenfell Fire

A plan has been developed aiming to reduce the risk of suicide within the population affected by the Grenfell fire. It builds upon the offer already in place and sits within and is supported by the overall strategy for suicide prevention in the three boroughs.

All partners supporting the crisis and recovery response after the Grenfell Fire are very concerned about any potential risk for an increase in the number of suicides and attempted suicides, and the potential for the development of 'suicide clusters'. Whilst studies show different patterns of suicide mortality following natural disasters,[4] clearly every disaster is unique and potential outcomes difficult to predict. The Grenfell Mental Health Delivery Group will be responsible for coordinating the implementation of the Grenfell Suicide Prevention Action Plan, with reporting responsibility to the Grenfell Health and Wellbeing Subgroup of the Community and People Programme Board. The Grenfell Mental Health Delivery Group will work in close liaison with the Suicide Prevention Strategy Steering Group for the three boroughs, recognising that at times greater impacts can be achieved through working at a broader rather than local level.

NHS Mental Health Services

The two main providers of mental health services in the boroughs are West London Mental Health Trust for Hammersmith & Fulham and Central and North West Mental Health Trust for Kensington and Chelsea and the City of Westminster. Both trusts have their own suicide prevention plans in place and will provide annual progress reports to the Suicide Prevention Steering Group.

Summary

This document is a work in progress which has been developed through dialogue with key stakeholders, the Suicide Prevention Working Group. The outline priorities and actions were discussed added to at the Suicide Prevention Consultation event which was run on 7th November 2017 and attended by a wide range of partners including from health, police, the third sector and the local authorities.

Questions for the Health and Wellbeing Board are:

- Have we got the right priorities?
- Have we got the right actions to deliver improvements against the identified priority areas?
- Are we tackling actions in the right order and with appropriate/feasible timescales?
- Are there sufficient resources available to deliver this action plan particularly from the Public Health Department? What other resources will be required or can be offered?

[4] http://www.wageningenacademic.com/doi/abs/10.3920/978-90-8686-806-3_8

7.0 Suicide Prevention Action Plan

This action plan contains actions already underway or whose funding has been signed off as well as ideas proposed by the working group and from wider the consultation.

Action Area 1: Reduce the risk of suicide in key high-risk groups:

Taking cross-cutting and coordinated approaches to address high risk groups is critical to maximising efforts to reduce suicide and improve mental health. Groups that have been chosen to focus on for the next three years include:

- Men aged 15 to 59
- People who have attempted suicide
- Substance misusers

Area for action	Key issue/target group	Intervention description	Suggested lead and key partners	Delivery time frame	Outcome/Impact
1.1	Reducing risk in men especially in middle age, with a focus on: economic factors such as debt; social isolation; drugs and alcohol; developing treatment and support settings that men are prepared to use.	Working group to draw up proposals for how to increase help seeking by men, in particular single white men aged 15-59 and MSM, including CAMHS for those young men aged 15-17. Identify individuals with lived experience for representation on working group.	**Public Health**, CALM, PAPYRUS, Working with Men, Opportunity for All, local football clubs, housing, major employers,	Working group formed by May 2018.	Report recommendations to inform future commissioning to the Suicide Prevention Working Group by July 2018.

1.3	People who have attempted suicide	Review and strengthen pathway for people attending A&E departments following suicide attempt. Ensure GPs are contacted with details of suicidal/vulnerable person so that appropriate help and support can be offered e.g. Public Protection Unit/Liaison Team	**NHS Acute Trusts** CNWL and WLMHT **CCG**	New 24/7 Crisis and Urgent Care delivery and pathway developing with integrated outreach team for CYP	Audit to investigate whether all those attending A & E Departments who have attempted suicide placed on the Crises Care and Urgent Care Delivery Pathway. CCG Audit to investigate whether GPs are contacted with details of suicidal/vulnerable people who have attended A & E departments so they can provide follow-up.
1.4	People who self-harm	Identify gaps in care relating to preventing and responding to self-harm, with a range of services for adults and young people in crisis, and psychosocial assessment for self-harm patients.	**NWL Collaborative of CCGs**, mental health trusts, school nursing	Ongoing, new24/7 Crisis and Urgent Care delivery and pathway developing with integrated outreach team for CYP	Care for people who self-harm in line with NICE Guidance.

		Explore establishing a peer to peer support group for self-harm based on recommended good practice.	PHE, CCG and CNWL	Start December 2018	Peer to peer support model established
1.5	Commissioning	Use contract mechanisms to ensure suicide awareness training is built into all contracts. Review current commissioned services for suicide prevention	**LA Commissioners** **CCG Commissioners**	CCG commissioners to discuss with contract leads for WLMHT and CNWL for insertion into 2017-19 contracts. By end of March 2018 LA commissioners to discuss with current providers and include in all new contracts.	All new contracts issued to include a requirement for suicide awareness, prevention and intervention training for all staff working with at risk groups. Develop a 'kitemark' standard to recognise /quality assured training providers.
1.6	First Responders	Suicide prevention and intervention training for all front line police, fire brigade and ambulance service staff.	**Public Health** Metropolitan Police, London Fire Brigade,	From December 2018	Increased reports of interventions.

		Mental Health and Suicide course for all BTP officers which will consist of 2 days of awareness and practical application of powers. This will be for every front line officer.	London Ambulance Service British Transport Police	From December 2017	
1.7	Voluntary sector to ensure a wide range of support is available in addition to the statutory services.	Work with the third sector to ensure that there is appropriate support for those who do not access traditional services. Work with universities and colleges to review their current arrangements for students in crisis.	**MIND, Samaritans**, Public Health, School Nurses, Educational Psychology, 'Kooth' on-line counselling for young people. **Public Health** Universities and colleges.	March 2019 March 2019	Report produced mapping the support available, and identification of gaps to inform commissioning intentions. Review completed and recommendations implemented by the universities and colleges.
1.8	Training	Roll out e-learning and face to face training to wider groups: banks, pubs, betting agencies, hostels, homeless shelters, licencing department Westminster City Hall	Suicide Prevention Group **Public Health**	December 2018 March 2019	Suicide Prevention Group to develop a suicide prevention training plan For example: Pilot engagement with

			Local Authority Licensing		Banks to include suicide prevention awareness as part of a wider mental health strategy. For example: CCG E-learning available to staff in hostels and homeless shelters For example: Work with a pub/bar chain to pilot mental health first aid and suicide prevention training. Report on the pilot to be shared with the Suicide Prevention Group. For example: Work with Samaritans to expand 'small talk, saves lives' media campaign directed at banks, pubs, betting agencies, hostels etc. ?

1.9	Mental health services- West London Mental Health Trust	West London Mental Health Trust have their own WLMHT Suicide Reduction Implementation Plan. The two action areas below include joint work with other organisations. • Reduce self-poisoning through reducing use of high risk medications and developing new prescribing guidance with CCGs. • Develop and implement an Information Sharing Policy with other professional including criminal justice agencies of in- patients with suicidal ideation.	**West London Mental Health Trust**	December 2019 December 2020	West London Mental Health Trust to share their Suicide Reduction Implementation Plan with the Suicide Prevention Group and report progress annually.
	Mental Health Services – CNWL NHS Foundation Trust	CNWL NHS Foundation Trust have their own suicide prevention action plan are included below include joint work with other organisations. • Working with Imperial College Patient Safety Collaborative on reducing suicide, implement an evidence based suicide prevention programme called Connecting with People.	**CNWL NHS Foundation Trust,** Imperial College Health Partners	Roll out of the learning from Brent pilot to other CMHTs – Sept 2018 – Sept 2019 December 2017 – December 2018	CNWL to share their Suicide Reduction Plan with the Suicide Prevention Group and report progress annually.

		• Improvement of safe leave and reduction of absent without leave or failure to return from leave. • Review of Clinical Risk Assessment and Management Policy and the use of additional tools for robust assessment of suicide risk and safety planning and this will be linked to SystmOne, which will embed the tools.		November 2017 – May 2018 review of policy and tools Training produced by February 2018 Trainer the trainer sessions March 2018	

Action Area 2: Tailoring approaches to improve mental health in specific groups

Area for action	Key issue/target group	Intervention description	Suggested lead and key partners	Delivery time frame	Outcome/Impact
2.1	Schools and Early Years	Healthy Schools and Healthy Early Years Partnerships to provide advice, guidance and recognition of achievement through the Bronze Silver and Gold Awards on emotional health and wellbeing and building resilience.	**Public Health Commissioners** / Healthy schools and Healthy Early Years Programmes	Ongoing March 2018	95% of primary schools and 80% of secondary schools to achieve and maintain Healthy Schools Bronze Award. Conferences focusing on Mental Health for both Healthy Schools and Healthy Early Years to promote improve practice and share learning and to include suicide prevention.
		0-19 Healthy Child Programme services (Health Visiting and School Nursing), commissioned by LAs require all front line staff to be trained tier 1 mental health workers.	**Public Health Commissioners**	October 2018	0-19 Healthy Child Programme Services contract requirement that all front line staff are Tier 1

					mental health worker trained.
2.2	Ensuring up to date information on services is easily accessible for individuals, care givers and service providers.	Update the mapping of services available from health, social care and third sector and ensure the information is easily available and effectively communicated.	**Public Health**/ Social Care Services/HealthWatch	Commissioned by September 2018 Published by November 2018	Information on services easily available for both residents and service providers in a variety of formats.
2.3	To better understand the mental wellbeing needs and issues for the local population.	The Health and Wellbeing Boards to commission a Joint Strategic Needs Assessment (JSNA) on mental health and wellbeing.	**Public Health**/Health and Wellbeing Boards	March 2019	JSNA completed and informs the Health and Wellbeing strategy.
2.5	Provision of specialist mental health promotion services for target groups	Review commissioned services which target the mental health of men, BME groups and those facing domestic violence e.g. CALM and Opportunity for All, highlighting suicide prevention interventions/effectiveness	**Public Health Commissioners**	April 2018	PH services for men and BME groups recommissioned, ensuring inclusion of suicide prevention specification.

Action Area 3: Provide better information and support to those bereaved or affected by suicide

Post-suicide interventions at family and community level are essential to deal with the effects of suicide, the risk of contagion and cluster suicides and the on-going impact on the mental health of the bereaved. There is a key role here for the police and the Coroner's office in offering immediate help to bereaved families in access to information and to find support from local and national organisations.

Area for action	Key issue/target group	Intervention description	Suggested lead and key partners	Delivery time frame	Outcome/Impact
3.1	Provide effective and timely support for families bereaved or affected by suicide	Immediate outreach after suspected suicide through a liaison role (with a named individual who is responsible for suicide bereavement support)	**Metropolitan Police/Coroner's Office**	July 2018	Police suicide liaison role established in each local authority area.
3.2	Those bereaved /affected by suicide	Critical incident response service to schools - Support offer to schools and siblings of those who have died by suicide Develop a pathway to improve the provision of support and information to those bereaved by suicide including provision of information e.g. "Help is at Hand" leaflet as well signposting to Samaritans/other charities	**Educational psychology service** to schools and Sixth Form colleges. **Public Health**, Police, Coroner, Registrar, GPs, Acute Health Trusts, Funeral Directors, Social Care	**Ongoing** **Pathway agreed by September2018** **Implemented by December 2018**	All schools aware that they can request support for themselves and for the siblings of those who have died by suicide. All those bereaved by suicide provided with the appropriate support and information.

		Survivors of Bereavement by Suicide (SOBS) peer support group to be set up.	**MIND/PAPYRUS**	**September 2018** **October 2018** **April 2019**	Plan for a SOBS peer support group drafted and presented to the Suicide Prevention Steering Group. Business Case Developed to secure funding. Survivors of Bereavement by Suicide (SOBS) peer support group established and widely promoted.

Action Area 4 Promoting a multiagency approach

Area for action	Key issue/target group	Intervention description	Suggested lead and key partners	Delivery time frame	Outcome/Impact
4.1	Improving sharing of information	Set up a mechanism to share confidential and other information between agencies on suicide prevention e.g. data, services.. e.g. website, sharepoint.	Public Health	December 2019	Increased appropriate referrals to services.
4.2	Ensuring the voice of the bereaved is heard	Agreement on a process for involving the bereaved in the suicide prevention working group.	Public health	September 2018	Action plan implementation reflects local need

Action Area 5 Improving data collection and monitoring

Reliable, timely and accurate suicide statistics are the cornerstone of any suicide prevention strategy and are of tremendous Public Health importance. Analysis of the circumstances surrounding suicides in an area can inform strategies and interventions, highlight trends and changes in patterns, identify key factors in suicide risk and enhance our understanding of high risk groups, evaluate and develop interventions to reflect changing needs and priorities, and develop the evidence base on what works in suicide prevention. An individual borough alone is too small an area to be able to collect sufficient data to be able to analyse for trends. It is therefore recommended that the boroughs of North West London collaborate to create a real time suicide surveillance mechanism.

Area for action	Key issue/target group	Intervention description	Suggested lead and key partners	Delivery time frame	Outcome/Impact
5.1	Real-time suicide surveillance for North West London	Establish a multi-agency approach to collecting real-time information about suicides and attempts.	**Like Minded,** LA Public Health Departments	April 2018 September 2018 September 2018	Suicide Surveillance Group established and meeting regularly Real-time suicide surveillance process in place. Data-sharing channels established within the correct information governance framework.

5.2	Managing suicide clusters and risk of contagion	Establish management of suicide clusters in line with recent national guidance (*ref*)	**Public Health** Roll out the work from the Grenfell Suicide Prevention Action Plan.	March 2020	Proccesses in place to manage suicide clusters.
5.3	Suspected suicides, injurious attempts and pre-suicidal/mental health incidents that have occurred on BTP jurisdiction	British Transport Police are working closely with the Samaritans to train staff and identify hotspots. Once locations are identified BTP and NWR/TfL to inform the Suicide Prevention Steering group. Establish a single point of contact in Public Health to link into the BTP early warning system. BTP and NWR/TfL to share their reports on suspected suicide or injury attempts with the Suicide Prevention Steering group.	**British Transport Police**, Metropolitan Police, TfL, CCG, Mental Health Trusts,	June 2018 April 2018	Multi-agency meeting held about hot-spots and a plan developed for their mitigation and management. Early warning system for suspected suicide or injury attempt agreed with the Public Health Department and in place. Reports presented to the Suicide Prevention Steering Group by the BTP on each suspected suicide/injurious attempt. Lessons learned from the report implemented.

Action Area 6: Supporting the media in delivering sensitive approaches to suicide and suicidal behaviour

The media – including newspapers, magazines, movies, advertising, websites, TV, radio and social media – are an important source which impacts how people perceive the world around them. Insensitive reporting around a suicide can have a wide range of negative impacts – both in terms of emotional impact particularly on those affected and on vulnerable groups, and in playing a role in potential suicide 'contagion'.

Journalists have a responsibility to report sensitively about suicide, whilst balancing this with keeping the public informed. The Samaritans have published guidance on media reporting of suicide, including both factual reporting of events and dramatic portrayal. Key points include:

- Avoid giving too much detail, such as the method, exact location or specific life circumstances of the person who has died by suicide
- Never say the method is quick, easy, painless or certain to result in death
- Avoid over-simplifying the context of the suicide
- Steer away from melodramatic depictions of suicide or its aftermath
- Do not sensationalise reports – avoid using words such as 'hotspots' or 'epidemic'
- Educate and inform – about wider associated issues, and always include helpline numbers
- Do not glamorise suicide – and do not say it is 'successful'

Area for action	Key issue/target group	Intervention description	Suggested lead and key partners	Delivery time frame	Outcome/Impact
6.1	London and national print; television and radio	Work with the GLA to organise a 'sign-up' event where the Samaritans can provide a 'refresher' of their guidance and ask outlets to sign a pledge to	**Local Authority Comms**, Like Minded, Thrive LDN, Samaritans, London Councils, GLA	June 2018	Sign-up event has been held with a number of media outlets attending and signing up to a

		report responsibly on mental health and suicide. Use similar Grenfell sign-up event as a template.			responsible reporting pledge.
6.2	Challenging Reporting	Complaints to be made to the Press complaints commission. Complaints to be co-ordinated to maximise impact.	Communication departments for Local Authority, GLA, CCG, NHS providers and voluntary sector.	October 2018	Complaints submitted in a timely and coordinated fashion.
6.3	Social media campaign	Capitalise on Thrive LDN which is supported by the Mayor of London.	**LA Comms, Like Minded**	April 2018	LA comms incorporate promotion of Thrive LDN in their comms plans
6.4	Social media	Explore the potential for social media platforms to come up with an automatic prompt " You look like you are having a hard time" directing people to sources of support in response to searches and key words.	Thrive London, Like Minded, PHE, Samaritans	June 2018	LA Public Health to discuss with Thrive LDN an approach to social media platforms about directing people to sources of support.

8.0 Grenfell Suicide Prevention Action Plan

The Grenfell Suicide Prevention action plan **(add hyperlink)** sets out a plan aiming to reduce the risk of suicide within the population affected by the Grenfell Fire, and builds upon the offer already in place. It is important to bear in mind that not everyone affected by Grenfell is either from (or remain in) the local area. There may have been visitors to the area at the time of the fire, and those who are suffering the loss of family and friends may be distributed both nationally and internationally. People who were resident in the tower or nearby at the time of the fire will not necessarily continue to live in the local area. This is a major challenge for both the monitoring of suicidal behaviour and for the provision of an offer to all those affected.

Whilst the action plan discusses specific interventions to reduce the risk of suicide, it is also considering a more upstream approach, which looks at how to improve mental wellbeing and resilience to avoid people developing suicidal thoughts in the first place. As such, in addition to the implementation of suicide-specific strategies, attention is given to the continuing development of the good work already occurring to support the community, in order to support a holistic and more effective approach.

The Strategy and Action Plan have been developed in conjunction with this Suicide Prevention Strategy, Community Engagement Plan and multi-agency Communications Plan and was ratified by the Communities & People Board on 7th December 2017.

9.0 Appendix A

NICE Guidelines

NICE guidelines related to suicide prevention:

Self-harm in over 8s: short-term management and prevention of recurrence (2004) NICE guideline CG16

Depression in adults: recognition and management (2009) NICE guideline CG90

Self-harm in over 8s: long-term management (2011) NICE guideline CG133

Borderline personality disorder: recognition and management (2009) NICE guideline CG78

Bipolar disorder: assessment and management (2014) NICE guideline CG185

Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence (2011) NICE guideline CG115

Depression in adults with a chronic physical health problem: recognition and management (2009) NICE guideline CG91

Common mental health problems: identification and pathways to care (2011) NICE guideline CG123

Antisocial behaviour and conduct disorders in children and young people: recognition and management (2013) NICE guideline CG158

Psychosis and schizophrenia in adults: prevention and management (2014) NICE guideline CG178

Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges (2015) NICE guideline NG11.

Mental wellbeing in over 65s: occupational therapy and physical activity interventions (2008) NICE guideline PH16

Social and emotional wellbeing in secondary education (2009) NICE guideline PH20

Mental wellbeing at work (2009) NICE guideline PH22

Alcohol-use disorders: prevention (2010) NICE guideline PH24

Looked-after children and young people (2010) NICE guideline PH28

NICE guidance on the experience of people using the NHS:

Patient experience in adult NHS services (2012) NICE guideline CG138

Service user experience in adult mental health (2011) NICE guideline CG136

Medicines adherence (2009) NICE guideline CG76

NICE guidance on community engagement:

Community engagement: improving health and wellbeing and reducing health inequalities (2016). NICE guideline NG44