NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Health and social care directorate

Quality standards and indicators

Briefing paper

Quality standard topic: Suicide prevention

Output: Prioritised quality improvement areas for development.

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Contents

1 Introduction

This briefing paper presents a structured overview of potential quality improvement areas for suicide prevention. It provides the committee with a basis for discussing and prioritising quality improvement areas for development into draft quality statements and measures for public consultation.

1.1 Structure

This briefing paper includes a brief description of the topic, a summary of each of the suggested quality improvement areas and supporting information.

If relevant, recommendations selected from the key development sources below are included to help the committee in considering potential statements and measures.

1.2 Development sources

The key development sources referenced in this briefing paper are:

- Preventing suicide in community and custodial settings (2018) NICE guideline NG105
- Mental health of adults in contact with the criminal justice system (2017) NICE guideline NG66
- Transition between inpatient mental health settings and community or care home settings (2016) NICE guideline NG53
- Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services (2011) NICE guideline CG136
- Self-harm in over 8s: long-term management (2011) NICE guideline CG133. This guideline was checked in January 2019 and it was agreed to update it at the earliest opportunity.
- Common mental health problems: identification and pathways to care (2011) NICE guideline CG123
- Depression in adults with a chronic physical health problem: recognition and management (2009) NICE guideline CG91
- Depression in adults: recognition and management (2009) NICE guideline CG90. This guideline was reviewed in December 2013 and is being updated.
- Self-harm in over 8s: short-term management and prevention of recurrence (2004) NICE guideline CG16. This guideline was checked in January 2019 and it was agreed to update it at the earliest opportunity.

2 Overview

2.1 Focus of quality standard

This quality standard will cover ways to reduce suicide and help people bereaved or affected by suicides in community and custodial settings. It does not cover national strategies, general mental wellbeing, or areas such as treatment and management of self-harm or mental health conditions covered by other NICE quality standards.

2.2 Background

Suicide and self-harm are major public health problems, with someone who self-harms being at increased risk of suicide (The Chief Medical Officer annual report: public mental health priorities – investing in the evidence Department of Health). Suicides are not inevitable. There are many ways in which services, communities, individuals and society as a whole can help to prevent suicides.

Overall, the financial cost of someone of working age dying by suicide in the UK is more than £1.6 million (Evaluation of the first phase of Choose Life: the national strategy and action plan to prevent suicide in Scotland Scottish Executive Social Research).

Approximately two thirds of people who die by suicide have not had recent contact with mental health services at the time of their death. However, many may have seen their GP in the year before they died and others may have been seen in A&E or another setting. People at risk of dying by suicide may come into contact with a wide range of professionals and others. The Department of Health and Social Care's suicide prevention strategy for England and the Commons Health Committee's report on the government's suicide prevention strategy highlights the potential role of the community in preventing suicide.

The need to develop local suicide prevention strategies and action plans that engage a wide network of stakeholders in reducing suicide is identified in the national suicide prevention strategy. In England, responsibility for the suicide prevention action plan and strategy usually lies with local government through health and wellbeing boards.

The Five Year Forward View for Mental Health set out an ambition to reduce the number of suicides in England by 10 per cent by 2020. The NHS Long-term Plan reaffirms the NHS's commitment to make suicide prevention a priority over the next decade. It commits to rolling out funding to further Sustainability and Transformation Partnership (STP) areas, implementing a new Mental Health Safety Improvement Programme, as well as rolling out suicide bereavement services across the country.

2.3 Incidence and prevalence

In 2017 there were 5,821 suicides registered in the UK, an age-standardised rate of 10.1 deaths per100,000 population (Suicides in the UK: 2017 registrations Office for National Statistics). This is one of the lowest rates observed since the suicide data series began in 1981, when the rate was 14.7 deaths per 100,000. Suicide is more than 3 times as common in men as in women. The suicide rate among women in the UK has halved since 1981. The rate among men has fallen by around a quarter over the equivalent period. In 2017, the highest age-specific suicide rate was 24.8 deaths per 100,000 among males aged 45 to 49 years; for females, the age group with the highest rate was 50 to 54 years, at 6.8 deaths per 100,000.

The risk of suicide in the UK prison population is considerably higher than among the general population. The 3-year average rate of self-inflicted deaths by people in prison in England was 69 per 100,000 between 2009 and 2011; approximately 80% received a suicide or open verdict at inquest. There were 57 'apparent suicides following police custody' during 2017/18 in England and Wales[1] and 92 ‘apparent self-inflicted deaths’ in prison in England and Wales in 2018[2] (1.1 per 1,000 prisoners).

The suicide prevention strategy for England identifies the following high-risk groups:

- young and middle-aged men;
- people in the care of mental health services, including inpatients;
- people in contact with the criminal justice system;
- specific occupational groups, such as doctors, nurses, veterinary workers, farmers and agricultural workers; and
- people with a history of self-harm.

[1] Independent Office for Police Conduct Deaths during or following police contact: Statistics for England and Wales 2017/18
[2] Ministry of Justice Safety in Custody Statistics, England and Wales: Deaths in Prison Custody to December 2018

3 Summary of suggestions

3.1 Responses

In total 21 stakeholders responded to the 2-week engagement exercise 5/11/18 to 26/11/18. The Department of Health and Social Care confirmed that they had no substantive comments to make.

Stakeholders were asked to suggest up to 5 areas for quality improvement. Specialist committee members were also invited to provide suggestions. The responses have been merged and summarised in table 1 for further consideration by the committee.

Full details of all the suggestions provided are given in appendix 2 for information.

Table 1 Summary of suggested quality improvement areas

Suggested area for improvement	Stakeholders
Partnership working	
• Multi-agency partnership	• DHFT, FLD, HMPPS, LGA, NSPA, NCD, NWBHFT, SCMs, TS
• Intelligence-based strategy and action plan	• FLD, INQ, LGA, NHSE, NSPA, NWBHFT, PHE, RCGP, RCPCH, SCMs, TS
Awareness and communication	
• Awareness raising	• BS, CMHP, DHFT, FLD, NSPA, NCD, NHSE, RCGP, SCM, TS
• Media communication	• NSPA, SCM, TS
Reducing access to methods of suicide	• INQ, NHSI, NCD, NWBHFT, RCGP, RCPsych, SCM
Identifying people at risk	• INQ, LGA, NSPA, NWBHFT, PHE, RCGP, RCN, RCPsych, SCMs, TS
Supporting people at risk	
• Support for people at risk	• BS, DHFT, HMPPS, INQ, PUK, RCN, WBC
• Information sharing	• DHFT, HMPPS, INQ, PHE, RCGP, RCN,
Supporting people bereaved or affected by suicide	• BS, DHFT, HMPPS, LGA, NSPA, NCD, NWBHFT, PHE, RCGP, RCN, SCMs, NHSE, TS, WBC,
Additional areas	
• Training and skills	• CMHP, RCGP, SCMs, NHSE
• Managing transitions	• BS, INQ, NCD, STMS
• NHS Health Checks	• WBC
• People with coexisting mental illness and substance misuse	• NCD, WBC
• Trigeminal neuralgia	• TNAUK
• Evaluation and research	• CMHP
• National legal/performance framework	• FLD

BS, Body & Soul
CMHP, College of Mental Health Pharmacy
DHFT, Derbyshire Healthcare NHS Foundation Trust
FLD, Festival of Life and Death
HMPPS, HM Prison and Probation Service
INQ, INQUEST
LGA, Local Government Association
NCD, National Clinical Director
NHSE, NHS England - the Office of the Chief Allied Health Professions Officer
NHSI, NHS Improvement,
NSPA, National Suicide Prevention Alliance
NWBHFT, North West Boroughs Healthcare NHS Foundation Trust
PHE, Public Health England
PUK, Parkinson's UK
RCGP, Royal College of General Practitioners
RCN, Royal College of Nursing
RCPCH, Royal College of Paediatrics and Child Health
RCPsych, Royal College of Psychiatrists
SCMs, Specialist Committee Members
STMS, Smart rTMS Ltd
TNAUK, Trigeminal Neuralgia Association UK
TS, The Samaritans
WBC, Warrington Borough Council

3.2 Identification of current practice evidence

Bibliographic databases were searched to identify examples of current practice in UK health and social care settings; 243 papers were identified for suicide prevention. In addition, 84 papers were suggested by stakeholders at topic engagement and 60 papers internally at project scoping.

Of these papers, 11 have been included in this report and are included in the current practice sections where relevant. Appendix 1 outlines the search process.

4 Suggested improvement areas

4.1 Partnership working

4.1.1 Summary of suggestions

Multi-agency partnership

Stakeholders highlighted the importance of establishing an effective multi-agency partnership for suicide prevention with board-level support and robust governance arrangements. In some local areas it was suggested that there needs to be more focus on involving specific partners including A&E liaison teams, primary care, schools, colleges, and universities. It was also suggested that there needs to be more focus on supporting people with 'lived experience' to be involved. It was highlighted that there should be separate partnerships in the community and in custodial settings which are linked. There was a concern that the composition and functioning of suicide prevention partnerships is highly variable across the country.

Intelligence-based strategy and action plan

Stakeholders suggested that it is important for multi-agency partnerships to have a strategy and action plan to provide a clear framework for the co-ordination of activities and resources to meet the needs of local communities. It was suggested that residential, custodial and detention settings are less likely to have a suicide prevention plan than community settings.

Stakeholders suggested that strategies and action plans should be based on robust analysis of data and intelligence from a wide range of sources. Access to real-time suicide surveillance data, with appropriate data sharing and safeguarding processes, was suggested as a priority to help tailor local interventions to prevent suicide, identify people who may need support and respond to emerging patterns and suicide clusters. The importance of ensuring that data collection and analysis recognises the specific factors surrounding suicide in young people was highlighted.

4.1.2 Selected recommendations from development source

Table 2 below highlights recommendations that have been provisionally selected from the development sources that may support potential statement development. These are presented in full after table 2 to help inform the committee's discussion.

Table 2 Specific areas for quality improvement

Suggested quality improvement area	Suggested source guidance recommendations
Multi-agency partnership	**Suicide prevention partnerships** NICE NG105 Recommendations 1.1.1 to 1.1.6

Intelligence-based strategy and action plan	**Suicide prevention strategies** NICE NG105 Recommendations 1.2.1, 1.2.2 and 1.2.4 **Suicide prevention action plans** NICE NG105 Recommendation 1.3.1 **Gathering and analysing suicide-related information** NICE NG105 Recommendations 1.4.1 to 1.4.4

Suicide prevention partnerships

NICE NG105 – Recommendation 1.1.1

Local authorities should work with local organisations to:

- Set up a multi-agency partnership for suicide prevention. This could consist of a core group and a wider network of representatives.
- Identify clear leadership for the partnership.
- Ensure the partnership has clear terms of reference, based on a shared understanding that suicide can be prevented.

NICE NG105 – Recommendation 1.1.2

Ensure the partnership has clear governance and accountability structures. Include oversight from local health and care planning groups, for example health and wellbeing boards.

NICE NG105 – Recommendation 1.1.3

Include representatives from the following in the partnership's core group:

- clinical commissioning groups
- local public health services
- healthcare providers
- social care services
- voluntary and other third-sector organisations, including those used by people in high-risk groups
- emergency services
- criminal justice services
- police and custody suites
- people with personal experience of a suicide attempt, suicidal thoughts and feelings, or a suicide bereavement.

NICE NG105 – Recommendation 1.1.4

Set up a multi-agency partnership for suicide prevention in residential custodial and detention settings. This could consist of a core group and a wider network of representatives. Ensure the partnership has:

- clear leadership
- clear terms of reference, based on a shared understanding that suicide can be prevented
- clear governance and accountability structures.

NICE NG105 – Recommendation 1.1.5

Include representatives from the following in the partnership's core group:

- governors or directors in residential custodial and detention settings
- healthcare staff in residential custodial and detention settings
- staff in residential custodial and detention settings
- pastoral support services
- voluntary and other third-sector organisations
- escort custody services
- liaison and diversion services
- emergency services
- offender management and resettlement services
- people with personal experience of a suicide attempt, suicidal thoughts and feelings, or a suicide bereavement, to be selected according to local protocols.

NICE NG105 – Recommendation 1.1.6

Link the partnership with other relevant multi-agency partnerships in the community.

Suicide prevention strategies

NICE NG105 – Recommendation 1.2.1

Develop a multi-agency strategy based on the principles of the Department of Health and Social Care's suicide prevention strategy for England and other relevant strategies. It should emphasise that suicide is preventable, and it is safe to talk about it.

NICE NG105 – Recommendation 1.2.2

Identify clear leadership for the multi-agency strategy.

NICE NG105 – Recommendation 1.2.4

Review local and national data on suicide and self-harm to ensure the strategy is as effective as possible. See recommendation 1.4.2.

Suicide prevention action plans

NICE NG105 – Recommendation 1.3.1

Develop and implement a plan for suicide prevention and for after a suspected suicide. Ensure the approach can be adapted according to which agencies are likely to spot emerging suicide clusters:

- Identify clear leadership for the action plan.
- Interpret data to determine local patterns of suicide and self-harm, particularly among groups at high suicide risk.
- Compare local patterns with national trends.
- Prioritise actions based on the joint strategic needs assessment and other local data to ensure the plan is tailored to local needs.
- Map stakeholders and their suicide prevention activities (including support services for groups at high risk).
- Share experience and knowledge between stakeholders. Also share data, subject to local information sharing agreements.
- Keep up-to-date with suicide prevention activities by organisations in neighbouring settings.
- Oversee local suicide prevention activities, including awareness raising and crisis planning.
- Review the action plan at a time agreed at the outset by the multi-agency partnership

Gathering and analysing suicide-related information

NICE NG105 – Recommendation 1.4.1

Use routinely collected data from sources such as Public Health England's Fingertips tool (public health profiles) or HM Prisons and Probation Service.

NICE NG105 – Recommendation 1.4.2

Collect and analyse local data on suicide and self-harm. This could include data on: method, location, timing, details of individual and local circumstances, demographics, occupation and characteristics protected under the Equality Act 2010. Sources could include reports from:

- the local ombudsman
- the Parliamentary and Health Service Ombudsman
- coroners
- the Prison and Probation Ombudsman
- the voluntary sector.

NICE NG105 – Recommendation 1.4.3

For community settings, also use rapid intelligence gathering (continuous and timely collection of data) to identify suspected suicides, emerging methods and potential suicide clusters. This intelligence could also be used to identify people who need support after such events (see recommendations 1.8.1 and 1.9.1). Collect this local data from a range of sources including:

- police and transport police
- prisons
- immigration removal centres (IRCs)
- coroners.

NICE NG105 – Recommendation 1.4.4

For residential custodial and detention settings, also collect data on:

- sentencing or placement patterns
- sentence type
- offence
- length of detention
- transition periods (for example, 'early days' and transitions between estates or into the community).

4.1.3 Current UK practice

Multi-agency partnership

A 2014 survey carried out by the All-Party Parliamentary Group on Suicide and Self-Harm Prevention[3] indicated that around 40% of local authorities did not have a multi-agency suicide prevention group.

[3] The All-Party Parliamentary Group (APPG) on Suicide and Self-Harm Prevention (2015) Inquiry into Local Suicide Prevention Plans in England

Intelligence-based strategy and action plan

A guide to effective scrutiny of local strategies to prevent or reduce suicide[4] highlights that local suicide prevention plans in England are not legal requirements but have been recommended by several reviews and reports.

The 2014 All-Party Parliamentary Group on Suicide and Self-Harm Prevention[5] indicated that around 30% of local authorities did no suicide audit work and around 30% did not have a suicide prevention action plan.

The 2019 4th progress report of the government's suicide prevention strategy[6] indicated that every local area had a multi-agency suicide prevention plan in place or in development. In addition, Sustainable Transformation Partnership (STP) areas with a high level of need are receiving NHS England funding as part of the £25 million investment in suicide prevention to improve and embed their plans.

The 2019 national progress report also highlighted that to improve safety and reduce suicide and self-harm in prison, the Ministry of Justice and HM Prison and Probation Service Prison Safety Programme will ensure all prison establishments have local multi-agency action plans for suicide prevention and self-harm reduction, linked to local authority plans. Public Health England is leading work to strengthen the links between prisons and local authority plans to improve the support provided to people when they are released from prison.

A zero-suicide ambition for mental health inpatients was announced in January 2018. The ambition recognises the need for a renewed emphasis on suicide prevention for those in inpatient care. All mental health trusts are producing plans for implementing a zero-suicide ambition by the end of 2018/19. The Zero Suicide Alliance[7] aims to deliver several projects including providing suicide awareness and prevention training to NHS staff and across local communities and other sectors, developing a model for NHS Trusts to better respond and learn from suicides, developing digital suicide prevention resources, and developing work on predictive analytics to improve the identification of suicide risk.

4.1.4 Resource impact

The resource impact will depend on current progress made towards implementing existing policies and strategies and will vary at a local level. Potential costs could include providing training to staff involved in partnership working, undertaking suicide

[4] Centre for Public Scrutiny (2018) Providing a lifeline: Effective scrutiny of local strategies to prevent or reduce suicide
[5] The All-Party Parliamentary Group (APPG) on Suicide and Self-Harm Prevention (2015) Inquiry into Local Suicide Prevention Plans in England
[6] H M Government (2019) Preventing suicide in England: Fourth progress report of the cross-government outcomes strategy to save lives
[7] HM Government (2019) Cross-Government Suicide Prevention Workplan

audits, data collection and analysis to inform the development of suicides plans and strategies.

4.2 Awareness and communication

4.2.1 Summary of suggestions

Awareness raising

Stakeholders highlighted the importance of raising awareness of suicide to reduce stigma, encourage help-seeking, help to identify people at risk, and draw attention to the support available locally, using evidence-based approaches. It was suggested that there is a need to target at risk communities such as middle-aged men, children and young people, and people in custodial settings. It was also suggested that it is important to engage with employers to promote suicide prevention in the workplace. There was a concern that there is currently duplication of effort at a local level and inconsistency of messages.

Media communication

Responsible communication of suicide was highlighted as a priority. It is important that there is an awareness of the potential harmful effects of media reporting of suicide and the need for responsible communication. Stakeholders suggested that it is important for partnerships to identify a lead for media reporting of suicide.

4.2.2 Selected recommendations from development source

Table 3 below highlights recommendations that have been provisionally selected from the development sources that may support potential statement development. These are presented in full after table 3 to help inform the committee's discussion.

Table 3 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Awareness raising	**Awareness raising by suicide prevention partnerships** NICE NG105 Recommendations 1.5.1, 1.5.3, 1.5.4, 1.5.5 and 1.5.6
Media communication	**Reducing the potential harmful effects of media reporting of a suspected suicide** NICE NG105 Recommendations 1.10.1, 1.10.2, 1.10.4

Awareness raising by suicide prevention partnerships

NICE NG105 Recommendation 1.5.1

Consider local activities to:

- raise community awareness of the scale and impact of suicide and self-harm

- reduce the stigma around suicide and self-harm
- address common misconceptions by emphasising that:
- suicide is not inevitable and can be prevented
- asking someone about suicidal thoughts does not increase risk
- make people aware of the support available nationally and locally
- encourage help-seeking behaviours
- encourage communities to recognise and respond to a suicide risk.

NICE NG105 Recommendation 1.5.3

Take into account socioeconomic deprivation, disability, physical and mental health status, and cultural, religious and social norms about suicide and help-seeking behaviour, particularly among groups at high suicide risk.

NICE NG105 Recommendation 1.5.4

Ensure the language and content of any awareness-raising materials is:

- appropriate for the target group
- sensitive and compliant with media reporting guidelines, such as the Samaritans' Media guidelines for the reporting of suicide.

NICE NG105 Recommendation 1.5.5

Coordinate local activities and ensure they are consistent – and coordinated – with national initiatives.

NICE NG105 Recommendation 1.5.6

Consider encouraging employers to develop policies to raise suicide awareness and provide support after a suspected suicide. For example, see Public Health England and Business in the Community's toolkits.

Reducing the potential harmful effects of media reporting of a suspected suicide

NICE NG105 Recommendation 1.10.1

Develop a clear plan for liaising with the media. Identify someone in the multi-agency partnership as the lead.

NICE NG105 Recommendation 1.10.2

For community settings, promote guidance on best practice for media reporting of suicide (including providers of social media platforms). Highlight the need to:

- use sensitive language that is not stigmatising or in any other way distressing to people who have been affected
- reduce speculative reporting
- avoid presenting detail on methods.

See: the World Health Organization's Preventing suicide: a resource for media professionals; the Samaritans' Media guidelines for reporting suicide; OFCOM's Broadcasting code; and the Independent Press Standards Organisation (IPSO).

4.2.3 Current UK practice

Awareness raising

8 STP areas that have been allocated transformation funding[8] are testing different approaches to reaching men in local communities as part of the multi-agency suicide prevention partnerships. This includes the 'It Takes Balls to Talk' campaign led by Warwickshire County Council and other local partners which targets men at sporting events and highlights the importance to men's mental wellbeing of them talking about their emotions.

In partnership with the rail industry, the Samaritans launched its campaign 'Small Talk Saves Lives' to increase the confidence and intent of people to talk to vulnerable people in the rail environment. The campaign reached 17 million people via social media, with 5.7 million people watching the campaign film. Evaluation of the campaign showed that it successfully changed people's behaviour, increasing their intent to take action, as well as increasing their understanding of how to recognise that someone needs help, and knowledge of how to intervene safely. A second phase of the 'Small Talk Saves Lives' campaign was launched in April 2018 on a much smaller scale which ran for eight weeks and focused on 15 'high risk' suicide locations.

The National Confidential Inquiry into Suicide and Safety[9] highlighted that preventing suicide in students requires specific measures, including:

- prevention, through promotion of mental health on campus
- awareness of risk, including the fact that conventional risk factors, e.g. alcohol or drug misuse, may be absent
- availability of support especially at times of risk, e.g. exam months
- strengthened links to NHS services, including mental health care

[8] H M Government (2019) Preventing suicide in England: Fourth progress report of the cross-government outcomes strategy to save lives
[9] University of Manchester (2018) National Confidential Inquiry in to Suicide and Safety in Mental Health: Annual Report

Media communication

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder's knowledge and experience

4.2.4 Resource impact

The resource impact will depend on current progress made towards implementing existing policies and strategies and will vary at a local level. However, potential costs to consider would include training programmes for front-line staff, local outreach campaigns to get the wider community involved, provision of posters, and other information on suicide prevention, using online or traditional advertising methods.

4.3 Reducing access to methods of suicide

4.3.1 Summary of suggestions

Stakeholders highlighted the importance of partnership action to reduce access to methods of suicide based on an understanding of local patterns of suicide method and location. This could include: physical measures such as barriers; improving the availability of crisis support at specific locations; improving ward safety. Specific risks that should be addressed were highlighted as follows:

- Staffing levels and skills on specialist mental health wards
- Removal of ligature points in NHS facilities
- Reduce primary care prescription of opioids, in particular, for people with mental health problems who are also prescribed psychotropic medication.

4.3.2 Selected recommendations from development source

Table 4 below highlights recommendations that have been provisionally selected from the development sources that may support potential statement development. These are presented in full after table 4 to help inform the committee's discussion.

Table 4 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Reducing access to methods of suicide	**Reducing access to methods of suicide** NICE NG105 Recommendations 1.6.1, 1.6.2, 1.6.3, 1.6.4

Reducing access to methods of suicide

NICE NG105 Recommendation 1.6.1

Use local data including audit, Office for National Statistics and NHS data as well as rapid intelligence gathering to:

- identify emerging trends in suicide methods and locations
- understand local characteristics that may influence the methods used
- determine when to take action to reduce access to the means of suicide.

NICE NG105 Recommendation 1.6.2

Ensure local compliance with national guidance to reduce access to methods of suicide:

- In custodial settings, for example, provide safer cells (see the Ministry of Justice's Quick-time learning bulletin: safer cells).
- In the community, for example, restrict access to painkillers (see NHS England's Items which should not be routinely prescribed in primary care: guidance for CCGs, Medicines and Healthcare products Regulatory Agency's Best practice guidance on the sale of medicines for pain relief [appendix 4 in the Blue guide], and Faculty of Pain Medicine's Opioids Aware).

NICE NG105 Recommendation 1.6.3

Reduce the opportunity for suicide in locations where suicide is more likely, for example by erecting physical barriers. Also see Public Health England's Preventing suicide in public places: a practice resource.

NICE NG105 Recommendation 1.6.4

Consider other measures to reduce the opportunity for suicide. For example, at locations where suicide is more likely, consider:

- providing information about how and where people can get help when they feel unable to cope
- using CCTV or other surveillance to allow staff to monitor when someone may need help
- increasing the number and visibility of staff, or times when staff are available.

4.3.3 Statements in existing quality standards

NICE QS34 Self-harm statement 5

People who have self‑harmed are cared for in a safe physical environment while in the healthcare setting, in order to reduce the risk of further self‑harm.

4.3.4 Current UK practice

The 2018 National Confidential Inquiry in to Suicide and Safety in Mental Health[10] concluded that a renewed emphasis on reducing suicide by in-patients is needed, in particular by (1) improving the physical safety of wards, with the removal of potential ligature points (2) care plans at the time of agreed leave (3) development of nursing observation as a skilled intervention. More generally, the inquiry recommended that key measures that services should take to reduce mental health patient suicide risk are:

[10] University of Manchester (2018) National Confidential Inquiry in to Suicide and Safety in Mental Health: Annual Report

- follow up within 2-3 days after hospital discharge
- safe prescribing of opiates and psychotropic drugs
- reducing alcohol and drug misuse.

The National Confidential Inquiry into Suicide and Homicide 2017[11] concluded that clinicians and pharmacists should be aware of the potential risks of opiate and opiate-containing analgesics. Safer prescribing in primary and secondary care remains crucial, particularly for patients with long-term pain, a group at high suicide risk. This should include prescribing only short-term supplies and enquiring about opiate-containing painkillers kept at home.

4.3.5 Resource impact

The resource impact will depend on current progress made towards implementing existing policies and strategies and will vary at a local level. However, potential costs to consider would include installing CCTV or other surveillance or physical barriers and staffing (increasing staff visibility) at locations where suicide is most likely to occur. Costs may also include staff training and the provision of information.

[11] University of Manchester (2017) National Confidential Inquiry into Suicide and Homicide: Annual Report

4.4 Identifying people at risk

4.4.1 Summary of suggestions

Stakeholders highlighted the importance of ensuring that front line staff such as GPs, people working in mental health, social care and custodial settings, and also those working in wider community settings, know how to identify people who are at risk of suicide and are confident to ask about suicide ideation in a non-judgmental manner.

High risk groups were identified as: people with long-term physical health problems in particular those with chronic pain; people who self-harm; people with drug and alcohol problems; people who have attempted suicide; people who have a family history of suicide; people with mental health problems in particular a diagnosis of a personality disorder and/or inpatient treatment; middle-aged men, older people who have an unrecognised mental health problem; and people who have recently started oral contraceptives.

There was concern that there is currently a reliance on risk assessment checklist tools to identify suicide risk which are not accurate. In mental health inpatient settings it was suggested that holistic ‘big picture’ risk assessments are needed, supported by appropriate information sharing and communication. In prisons, it was suggested that it is important to focus on individual risk factors rather than prison level risk factors.

4.4.2 Selected recommendations from development source

Table 5 below highlights recommendations that have been provisionally selected from the development sources that may support potential statement development. These are presented in full after table 5 to help inform the committee’s discussion.

Table 5 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Identifying people at risk	**Assessment of risk (specialist mental health professionals)** NICE CG16 Recommendation 1.7.3.1 **Assessment and coordination of care** NICE CG28 Recommendation 1.1.3.2 **Principles of assessment, coordination of care and choosing treatments** NICE CG90 Recommendation 1.1.4.6 NICE CG91 Recommendation 1.1.3.6 **Assessment** NICE CG123 Recommendation 1.3.2.9 **Risk assessment** NICE CG133 Recommendations 1.3.6, 1.3.10 and 1.3.11 **First-stage health assessment at reception into prison** NICE NG66 Recommendation 1.3.5 **Training by suicide prevention partnerships** NICE NG105 Recommendation 1.7.4

Assessment of risk (specialist mental health professionals)

NICE CG16 Recommendation 1.7.3.1

All people who have self-harmed should be assessed for risk; this assessment should include identification of the main clinical and demographic features known to be associated with risk of further self-harm and/or suicide, and identification of the key psychological characteristics associated with risk, in particular depression, hopelessness and continuing suicidal intent.

Assessment and coordination of care

NICE CG28 Recommendation 1.1.3.2

In the assessment of a child or young person with depression, healthcare professionals should always ask the patient and their parent(s) or carer(s) directly about the child or young person's alcohol and drug use, any experience of being bullied or abused, self-harm and ideas about suicide. A young person should be offered the opportunity to discuss these issues initially in private.

Principles of assessment, coordination of care and choosing treatments

NICE CG90 Recommendation 1.1.4.6 & NICE CG91 Recommendation 1.1.3.6 & NICE CG123 Recommendation 1.3.2.9

Always ask people with depression (and a chronic physical health problem) (a common mental health disorder) directly about suicidal ideation and intent.

Risk assessment

NICE CG133 Recommendation 1.3.6

When assessing the risk of repetition of self-harm or risk of suicide, identify and agree with the person who self-harms the specific risks for them, taking into account:

- methods and frequency of current and past self-harm
- current and past suicidal intent
- depressive symptoms and their relationship to self-harm
- any psychiatric illness and its relationship to self-harm
- the personal and social context and any other specific factors preceding self-harm, such as specific unpleasant affective states or emotions and changes in relationships
- specific risk factors and protective factors (social, psychological, pharmacological and motivational) that may increase or decrease the risks associated with self-harm
- coping strategies that the person has used to either successfully limit or avert self-harm or to contain the impact of personal, social or other factors preceding episodes of self-harm
- significant relationships that may either be supportive or represent a threat (such as abuse or neglect) and may lead to changes in the level of risk
- immediate and longer-term risks.

NICE CG133 Recommendation 1.3.10

Be aware that all acts of self-harm in older people should be taken as evidence of suicidal intent until proven otherwise.

NICE CG133 Recommendation 1.3.11

Do not use risk assessment tools and scales to predict future suicide or repetition of self-harm.

First-stage health assessment at reception into prison

NICE NG66 Recommendation 1.3.5

The first-stage health assessment should include the questions and actions in table 1. It should cover:

- self-harm and suicide risk.

Training by suicide prevention partnerships

NICE NG105 Recommendation 1.7.4

Ensure suicide awareness and prevention training helps people to:

- encourage others to talk openly about suicidal thoughts and to seek help (this includes providing details of where they can get this help)
- take into account socioeconomic deprivation, disability, physical and mental health status, and cultural, religious and social norms about suicide and help-seeking behaviour, particularly among groups at high suicide risk.

4.4.3 Statements in existing quality standards

NICE QS34 Self-harm Statement 2

People who have self‑harmed have an initial assessment of physical health, mental state, safeguarding concerns, social circumstances and risks of repetition or suicide.

4.4.4 Current UK practice

The National Confidential Inquiry into Suicide and Safety in Mental Health 2018[12] highlighted that recent self-harm is increasingly common as an antecedent of suicide in mental health patients but may not be given sufficient weight at assessment. The inquiry concluded that protocols for managing self-harm patients who are under mental health care should highlight the short term risk.

A survey of 70 GPs in Nottingham in 2016[13] found that the majority reported high levels of confidence in assessing and managing suicidality in young people. Experienced GPs demonstrated high levels of knowledge of suicide risk factors in young people but low levels of knowledge of warning signs that might indicate heightened risk. A qualitative study with GPs in Nottingham[14] indicated that they

[12] University of Manchester (2018) National Confidential Inquiry into Suicide and Safety in Mental Health: Annual Report
[13] Michail, Tait and Churchill (2017) General practitioners' clinical expertise in managing suicidal young people: implications for continued education Primary Health Care Research & Development 2017; 18: 419–428
[14] Michail and Tait (2015) Exploring general practitioners' views and experiences on suicide risk

found it challenging to distinguish between signs indicating imminent suicide risk from behavioural and affective changes that form part of 'normal adolescence'. Linked to this was a general uncertainty among GPs about distinguishing between what they called 'truly suicidal behaviour' and a 'cry for help' in young people.

A report on preventing prison suicide[15] highlighted that staff felt the initial reception assessment on arrival at prison consistently failed to detect and address vulnerability due to time constraints, staff skills and a lack of information from the court. The second part of the assessment comprises a follow-up interview, which is intended to provide an overall general health assessment. Staff highlighted that if the follow-up interview happened it was varied, with different levels of emphasis on mental health in different prisons. Given the high proportion of suicides that happen during the first month of prison, staff stressed the importance of improving the initial assessment process.

4.4.5 Resource impact

The resource impact depends on current progress made towards implementing existing policies and strategies and will vary at a local level. However, potential costs to consider would include training of staff to give them the knowledge and skills to identify signs and symptoms and to be confident to engage those at risk of committing suicide. Costs would depend on local need and service configuration.

assessment and management of young people in primary care: a qualitative study in the UK

[15] The Howard League for Penal Reform and Centre for Mental Health (2017) Preventing prison suicide: Staff perspectives

4.5 Supporting people at risk

4.5.1 Summary of suggestions

Support for people at risk

It was suggested that front line staff who identify someone at risk or someone who discloses suicidal intent should be able to help them to devise a safety plan. The safety plan should include referral to services available locally that can help them to address the causes of their distress.

There was a concern that people who have attempted suicide are not being referred for support. Commissioners should ensure there are good support systems in place including places of refuge where people can receive practical and psychological support.

It was highlighted that support for people at risk is currently focussed on clinical interventions including risk management, medication and psychological therapy. It was suggested that there should be more emphasis on non-clinical interventions including meaningful activities, peer support, and support with social problems such as housing and debt.

Information sharing

Stakeholders highlighted that there is a need to improve information sharing between professionals for people at risk of suicide in order to keep them safe and support continuity of care, including following discharge from prison or hospital. There was a concern that 'confidentiality' can be a barrier to communication.

Sharing information with families was emphasised as a priority so that they can help to support the person at risk. Families can also contribute to a broader assessment of the person's needs. It was suggested that the national consensus statement on 'Information sharing and suicide prevention' helps professionals decide when to inform family and friends about someone at risk of suicide as they can provide vital support.

4.5.2 Selected recommendations from development source

Table 6 below highlights recommendations that have been provisionally selected from the development sources that may support potential statement development. These are presented in full after table 6 to help inform the committee's discussion.

Table 6 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Support for people at risk	**Referral criteria** NICE CG28 Recommendations 1.3.2.2 and 1.3.2.3 **Principles of assessment, coordination of care and choosing treatments** NICE CG90 Recommendation 1.1.4.6 NICE CG91 Recommendation 1.1.3.6 **Assessment** NICE CG123 Recommendation 1.3.2.9 **Risk assessment and monitoring** NICE CG90 Recommendations 1.3.2.1 NICE CG91 Recommendations 1.3.2.1 NICE CG123 Recommendations 1.3.3.1 and 1.3.3.2 **First-stage health assessment at reception into prison** NICE NG66 Recommendation 1.3.5
Information sharing	**Consent and confidentiality** NICE CG133 Recommendation 1.1.13 **Safeguarding** NICE CG133 Recommendation 1.1.22 **Care and support across all points on the care pathway** NICE CG136 Recommendations 1.1.4, 1.1.14 and 1.1.15 **Support for families, parents and carers throughout admission** NICE NG53 Recommendation 1.4.5 **Principles of assessment** NICE NG66 Recommendation 1.2.1

Support for people at risk

Referral criteria

NICE CG28 Recommendation 1.3.2.2

For children and young people, the following factors should be used by healthcare professionals as criteria for referral to tier 2 or 3 CAMHS:

- active suicidal ideas or plans

NICE CG28 Recommendation 1.3.2.3

For children and young people, the following factors should be used by healthcare professionals as criteria for referral to tier 4 services:

- high recurrent risk of acts of self-harm or suicide

Principles of assessment, coordination of care and choosing treatments

NICE CG90 Recommendation 1.1.4.6 & NICE CG91 Recommendation 1.1.3.6 & NICE CG123 Recommendation 1.3.2.9

If there is a risk of self-harm or suicide:

- assess whether the person has adequate social support and is aware of sources of help
- arrange help appropriate to the level of risk
- advise the person to seek further help if the situation deteriorates.

Risk assessment and monitoring

NICE CG90 Recommendation 1.3.2.1 & NICE CG91 Recommendation 1.3.2.1

If a person with depression presents considerable immediate risk to themselves or others, refer them urgently to specialist mental health services.

NICE CG123 Recommendation 1.3.3.1

If a person with a common mental health disorder presents a high risk of suicide or potential harm to others, a risk of significant self-neglect, or severe functional impairment, assess and manage the immediate problem first and then refer to specialist services. Where appropriate inform families and carers.

NICE CG123 Recommendation 1.3.3.2

If a person with a common mental health disorder presents considerable and immediate risk to themselves or others, refer them urgently to the emergency services or specialist mental health services.

Longer-term treatment and management of self-harm

NICE CG133 Recommendation 1.4.4

A risk management plan should be a clearly identifiable part of the care plan and should:

- address each of the long-term and more immediate risks identified in the risk assessment
- address the specific factors (psychological, pharmacological, social and relational) identified in the assessment as associated with increased risk, with the agreed aim of reducing the risk of repetition of self-harm and/or the risk of suicide

- include a crisis plan outlining self-management strategies and how to access services during a crisis when self-management strategies fail
- ensure that the risk management plan is consistent with the long-term treatment strategy.

Inform the person who self-harms of the limits of confidentiality and that information in the plan may be shared with other professionals.

First-stage health assessment at reception into prison

NICE NG66 Recommendation 1.3.5 - Table 1 Questions for first-stage prison health assessment

Topic questions	Actions
Self-harm and suicide risk	
19. Is the person: • feeling hopeless or • currently thinking about or planning to harm themselves or attempt suicide?	Yes: refer the person for an urgent mental health assessment. Open an Assessment, Care in Custody and Teamwork (ACCT) plan if: • there are serious concerns raised in response to questions about self-harm, including thoughts, intentions or plans, or observations (for example, the patient is very withdrawn or agitated) or • the person has a history of previous suicide attempts. Be aware and record details of the impact of the sentence on the person, changes in legal status and first imprisonment, and the nature of the offence (for example, murder, manslaughter, offence against the person and sexual offences). No: record response.
20. Has the person ever tried to harm themselves, and if so: • do they have a history of suicide attempts • was this inside or outside prison • when was the most recent incident • what was the most serious incident?	Yes: refer the person for a mental health assessment if they have ever tried to harm themselves. No: record response.

Information sharing

Consent and confidentiality

NICE CG133 Recommendation 1.1.13

Be familiar with the principles of confidentiality with regard to information about a person's treatment and care, and be aware of the circumstances in which disclosure of confidential information may be appropriate and necessary.

Safeguarding

NICE CG133 Recommendation 1.1.22

Ask the person who self-harms whether they would like their family, carers or significant others to be involved in their care. Subject to the person's consent and right to confidentiality, encourage the family, carers or significant others to be involved where appropriate.

Care and support across all points on the care pathway

NICE CG136 Recommendation 1.1.4

When working with people using mental health services:

- be clear with service users about limits of confidentiality (that is, which health and social care professionals have access to information about their diagnosis and its treatment and in what circumstances this may be shared with others).

NICE CG136 Recommendation 1.1.14

Discuss with the person using mental health services if and how they want their family or carers to be involved in their care. Such discussions should take place at intervals to take account of any changes in circumstances, and should not happen only once. As the involvement of families and carers can be quite complex, staff should receive training in the skills needed to negotiate and work with families and carers, and also in managing issues relating to information sharing and confidentiality.

NICE CG136 Recommendation 1.1.15

If the person using mental health services wants their family or carers to be involved, encourage this involvement and:

- negotiate between the service user and their family or carers about confidentiality and sharing of information on an ongoing basis

Support for families, parents and carers throughout admission

NICE NG53 Recommendation 1.4.5

Respect the rights and needs of carers alongside the person's right to confidentiality. Review the person's consent to share information with family members, carers and other services during the inpatient stay.

Principles of assessment

NICE NG66 Recommendation 1.2.1

Work with a family member, partner, carer, advocate or legal representative when possible in order to get relevant information and support the person, help explain the outcome of assessment and help them make informed decisions about their care. Take into account:

- the person's wishes
- the nature and quality of family relationships, including any safeguarding issues
- any statutory or legal considerations that may limit family and carer involvement
- the requirements of the Care Act 2014.

4.5.3 Statements in existing quality standards

NICE QS48 Depression in children and young people Statement 3

Children and young people with suspected severe depression and at high risk of suicide are assessed by CAMHS (Child and Adolescent Mental Health Services) professionals within a maximum of 24 hours of referral. If necessary, children and young people are provided with a safe place while waiting for the assessment.

4.5.4 Current UK practice

Support for people at risk

The government's 4th progress report on the national suicide prevention strategy[16] highlighted that in June 2018, the James Wentworth-Stanley Memorial Fund opened James' Place in Liverpool, a non-clinical centre for men experiencing suicidal crisis. The centre is the first of its kind in the UK. The centre runs on a referral basis only, taking referrals from local hospitals, general practices and student counselling services. Visitors have an initial appointment to ascertain the treatment needed and then are offered a tailored service of one-to-one free therapeutic support during their time of need.

The progress report also highlighted recent investment and innovation in the development of children and young people's crisis support. In 2016, 8 urgent and emergency vanguard sites tested models of delivering urgent and emergency mental health care for children and young people. In 2017/8, additional funding was made available to CCGs to accelerate children and young people crisis and intensive home treatment services and provide alternatives to admission in the community.

[16] H M Government (2019) Preventing suicide in England: Fourth progress report of the cross-government outcomes strategy to save lives

The report on staff perspectives on preventing prison suicide[17] indicated that thresholds for mental health service referrals appeared to vary across prisons. Although prisoners can have multiple needs, often they do not meet the threshold for a mental health referral and therefore receive little support in prison. A report on the views of prisoners[18] found that they described a culture where, on the whole, distress was not believed or responded to with compassion. Mental health services in prison were mainly seen by prisoners as providers of medication.

An audit of follow-up in primary care at a GP teaching practice in the East of England for people who had presented with self-harm or suicidality between 2013 and 2018[19] found that there was documented evidence that 35 of the 44 people (80%) were asked about continuing suicidal thoughts or intent at their GP follow-up appointment and 30 (68%) were asked about continuing thoughts of or active self-harm behaviours. 5 people were asked about suicide without also being asked about self-harm, while 4 people were asked about self-harm but not suicide. 5 people were not asked about suicide or self-harm at all. Of these 5, 1 was under the care of the local CAMHS team but four patients who had not been asked about suicidality or self-harm in primary care were not referred to secondary services. 36 of the 44 people followed up in primary care were referred to secondary mental health services. Of those remaining under the care of the GP, 4 were encouraged to schedule a further follow-up appointment, however 4 left without a care plan in place that included follow up.

Information sharing

The 4th progress report on the national suicide prevention strategy[20] indicated that, based on feedback from the Royal Colleges, there are varied levels of confidence and knowledge across health professionals about when they may share information about suicide risk. Where a patient may express they do not wish their information to be shared then this becomes more complex for health professionals. It is expected that NHS England's national quality improvement programme for improving patient safety and suicide prevention across mental health services will include better sharing of information on risk between agencies and with the family where necessary.

[17] The Howard League for Penal Reform and Centre for Mental Health (2017) Preventing prison suicide: Staff perspectives
[18] The Howard League for Penal Reform and Centre for Mental Health (2016) Preventing prison suicide: Perspectives from the inside
[19] Bruco, Gamlin, Bradbury, Bill, Armour & Agius (2018) Self harm and suicidality: An audit of follow-up in primary care Psychiatria Danubina, 2018; Vol. 30, Suppl. 7, pp 610-615
[20] H M Government (2019) Preventing suicide in England: Fourth progress report of the cross-government outcomes strategy to save lives

The 2015 report of the National Confidential Enquiry into Suicide and Homicide by people with mental illness[21] indicated that families and carers are a vital but under-used resource in mental health care. The report suggested that closer working with families would have safety benefits:

- Services should consult with families from first contact, throughout the care pathway and when preparing plans for hospital discharge and crisis plans
- Staff should make it easier for families to pass on concerns about suicide risk and be prepared to share their own concerns.

4.5.5 Resource impact

The resource impact depends on current progress made towards implementing existing policies and strategies and will vary at a local level. However, potential costs to consider would include assessments, providing support services, and the training of staff to identify people at risk, and to have the knowledge and confidence to offer advice and refer to support services.

[21] University of Manchester (2015) National Confidential Inquiry into Suicide and Homicide by People with Mental Illness

4.6 Supporting people bereaved or affected by a suspected suicide

4.6.1 Summary of suggestions

Stakeholders highlighted the importance of ensuring that support is provided to people who are bereaved or affected by a suspected suicide. This includes family and friends, carers and first responders. People bereaved or affected by a suspected suicide are at increased risk of suicide.

It was suggested that it should be a priority to give the 'Help is at hand' booklet to people who are bereaved by suicide as soon as possible. There was a concern that the booklet is currently not always made available and a suggestion that coroners offices and funeral directors could help to improve this.

It was reported that there is currently local variation in the availability and type of postvention support services for people bereaved by suicide and how quickly support is put in place. It was suggested that it is important for bereaved families to be involved in developing and delivering support services. Sometimes access to support does not include the wider family. It was suggested that healthcare professionals need to be more proactive in identifying and referring people who have been bereaved for support.

4.6.2 Selected recommendations from development source

Table 7 below highlights recommendations that have been provisionally selected from the development sources that may support potential statement development. These are presented in full after table 7 to help inform the committee's discussion.

Table 7 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Supporting people bereaved or affected by a suspected suicide	**Supporting people bereaved or affected by a suspected suicide** NICE NG105 Recommendations 1.8.1 and 1.8.2

Supporting people bereaved or affected by a suspected suicide

NICE NG105 Recommendation 1.8.1

Use rapid intelligence gathering and data from other sources, such as coroners to identify anyone who may be affected by a suspected suicide or may benefit from bereavement support. Those affected may include relatives, friends, classmates, colleagues, other prisoners or detainees, as well as first responders and other professionals who provided support.

NICE NG105 Recommendation 1.8.2

Offer those who are bereaved or affected by a suspected suicide practical information expressed in a sensitive way, such as Public Health England's Help is at hand guide. (This also signposts to other services.) Ask them if they need more help and, if so, offer them tailored support.

4.6.3 Current UK practice

A qualitative study based on interviews with 13 GPs about experiences of dealing with suicide and bereavement[22] found that they disclosed low confidence in dealing with suicide and an unpreparedness to face parents whose adult offspring had died by suicide. Some GPs described guilt surrounding the suicide, and a reluctance to initiate contact with the bereaved parents. GPs talked of their duty to care for the bereaved patients, but admitted difficulties in knowing what to do, particularly in the perceived absence of other services. GPs reflected on the impact of the suicide on themselves and described a lack of support or supervision.

Analysis of survey data from the national confidential inquiry into suicide and homicide in England and Wales (2003 to 2012)[23] identified that relatives were not contacted by psychiatric professionals in 33% of suicide cases among psychiatric patients. The analysis found that a violent method of suicide was independently associated with greater likelihood of contact with relatives and four patient factors (forensic history, unemployment, and primary diagnosis of alcohol or drug dependence or misuse) were independently associated with less likelihood of contact with relatives. The research concluded that there is inequitable access to support after a potentially traumatic bereavement.

4.6.4 Resource impact

The resource impact will depend on current progress made towards implementing existing policies and strategies and will vary at a local level. However, potential costs to consider would be the provision of support and ensuring there is available the relevant suite of services needed.

[22] Emily Foggin, Sharon McDonnell, Lis Cordingley, Navneet Kapur, Jenny Shaw and Carolyn A Chew-Graham GPs' experiences of dealing with parents bereaved by suicide: a qualitative study Br J Gen Pract October 2016

[23] Alexandra L. Pitman, Isabelle M. Hunt, Sharon J. McDonnell, Louis Appleby, Navneet Kapur Support for Relatives Bereaved by Psychiatric Patient Suicide: National Confidential Inquiry Into Suicide and Homicide Findings Psychiatric Services 2017; 68:337–344; doi: 10.1176/appi.ps.201600004

4.7 Additional areas

Summary of suggestions

The improvement areas below were suggested as part of the stakeholder engagement exercise. However they were felt to be either unsuitable for development as quality statements, outside the remit of this particular quality standard referral or require further discussion by the committee to establish potential for statement development.

There will be an opportunity for the committee to discuss these areas at the end of the session on 20th February.

Training and skills

Stakeholders highlighted the importance of suicide prevention training for staff such as GPs, community pharmacists, nurses, police, and prison officers to improve their knowledge and confidence. There was a concern that there are a variety of training packages available but no consensus on quality. It was suggested that it is important for organisations to understand their role and contribution and they should adopt the National Collaborating Centre for Mental Health self-harm and suicide prevention competence framework.

Quality statements focus on actions that demonstrate high quality care or support, not the training that enables the actions to take place. Some stakeholder suggestions for training highlighted that it can improve the ability of staff to identify people at risk of suicide and to provide support. Those suggestions have been included within sections 4.4 and 4.5 of the briefing paper. The committee is therefore asked to consider whether there are any other components of care and support which would be improved by increased training. Training may be referred to in the structure measures and audience descriptors.

Managing transitions

Stakeholders suggested that there is a need for improved support and planning during transitions including discharge. There were specific concerns about transitions from child and adolescent mental health services (CAMHS) to adult mental health services and transfers of care from private sector mental health services to the NHS. It was suggested that there should be early follow up after specialist mental health care hospital discharge. There are separate quality standards on transition between inpatient mental health settings and community or care home settings (QS159) and transition from children's to adults' services (QS140). QS159 includes a statement on follow up after discharge for people with a risk of suicide.

NHS Health Checks

There was a suggestion that an assessment of mental health should be included in NHS Health Checks as a preventative measure. This could be a good way to target middle aged men who have an increased risk of suicide. This is beyond the scope of quality standards which are focussed on local rather than national initiatives.

People with coexisting mental illness and substance misuse

Stakeholders indicated that there is a need to improve services for people with coexisting mental illness and substance misuse as this group is at increased risk of suicide. There was a concern that people currently get caught in between different services due to unclear criteria. There is a separate quality standard on coexisting severe mental illness and substance misuse currently in development.

Trigeminal Neuralgia

It was suggested that there should be improved awareness of trigeminal neuralgia in order to ensure that a diagnosis is made as quickly as possible. It is also important that people are referred to a specialist as quickly as possible. People with trigeminal neuralgia experience considerable pain until drugs are given to alleviate the symptoms. The management of a specific condition is beyond the scope of this quality standard although section 4.4 of the briefing paper is focussed on identifying people who may be at risk of suicide and includes people with physical health conditions.

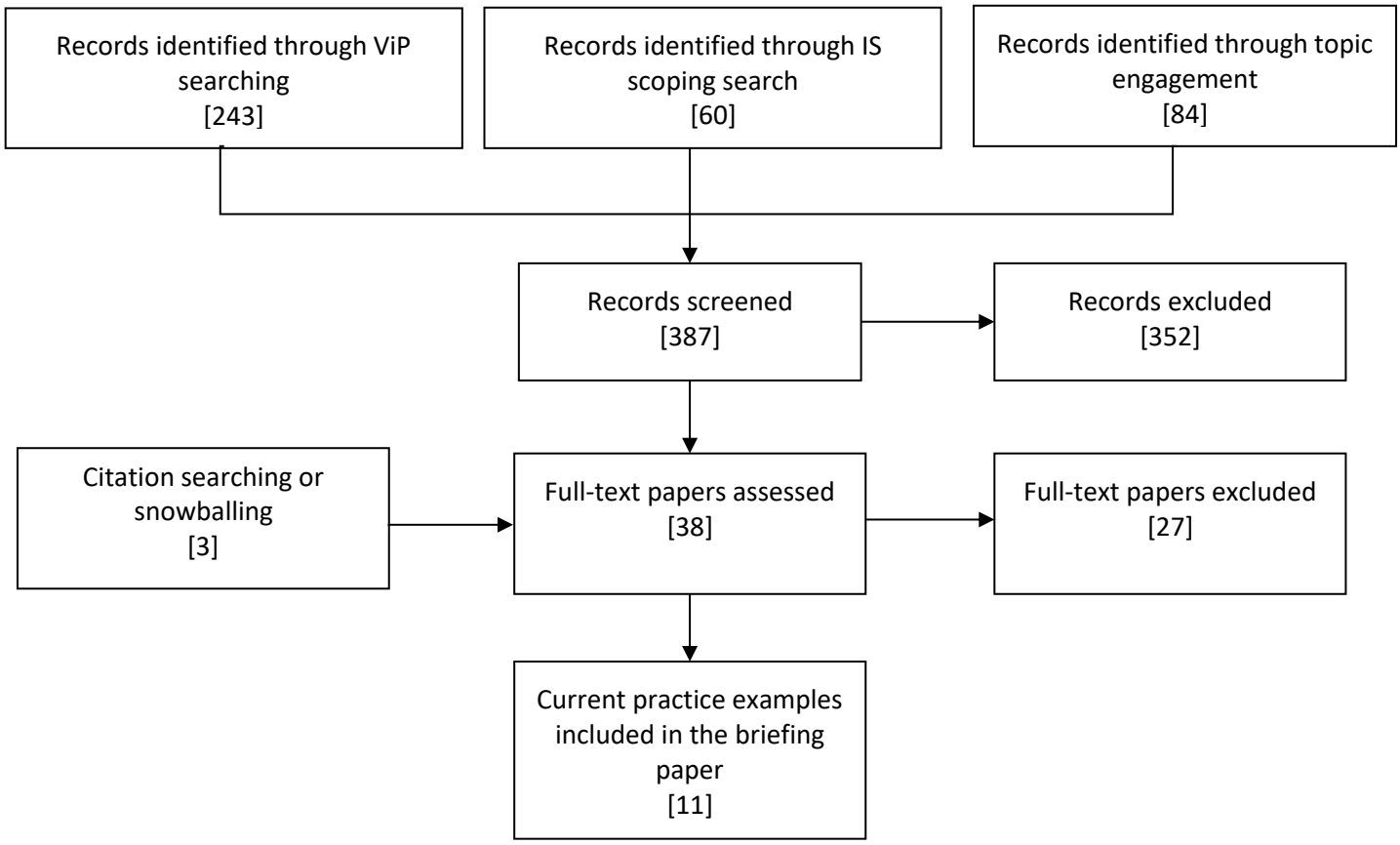
Evaluation and research

There was a suggestion that there is a need for more evaluation and research for suicide prevention initiatives in order to assess outcomes and improve learning. This will encourage uptake of evidence based approaches. Quality statements focus on actions that demonstrate high quality care or support, not the methods by which evidence is collated.

National legal and performance framework

It was suggested that there is a need to improve the national legal and performance framework to ensure that there is a clear aim to eliminate suicide, and businesses and organisations whose products are harmful to vulnerable people (gambling, debt, stress) can be prosecuted. This is beyond the scope of quality standards which are focussed on local rather than national initiatives.

Appendix 1: Review flowchart



Appendix 2: Suggestions from stakeholder engagement exercise – registered stakeholders

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
Partnership working – Multi-agency partnership					
1	Derbyshire Healthcare NHS Foundation Trust	Clear representation of A&E liaison teams on suicide prevention strategy groups	NICE Standard 1.1.3 Liaison teams as a health care resource are likely to encounter high numbers of people who self-harm and have suicidal ideation. So they being integral to a strategy group/forum, is a high priority.	Example of opportunity for intervention: Psychosocial assessment provision following an A&E attendance for self-harm and/or suicidal ideation is known to reduce future risk of self-harm and premature death (by up to 51% in some studies). However, psychosocial assessment rates are averaging ~55% of self-harm attendances nationally. This for all age groups. Yet there is no current standard/ advice for such services to be represented within strategy groups/ play a role in the development of suicide prevention strategies.	Kapur, N., Steeg, S., Webb, R., Haigh, M., Bergen, H., Hawton, K., ... & Cooper, J. (2013). Does clinical management improve outcomes following self-harm? Results from the multicentre study of self-harm in England. PloS one, 8(8), e70434. Bergen, H., Hawton, K., Waters, K., Cooper, J., & Kapur, N. (2010). Psychosocial assessment and repetition of self-harm: the significance of single and multiple repeat episode analyses. Journal of affective disorders, 127(1-3), 257-265. Geulayov G, Kapur N, Turnbull P, et al. Epidemiology and trends in non-fatal self-harm in three centres in England, 2000– 2012: findings from the Multicentre Study of Self-harm in England. BMJ Open 2016;6:e010538.
2	Festival of Life and Death	Additional developmental areas of emergent practice We must make use of all the millions 'lived experience' people who can	Only 'lived experience' people know truly what the answers are, and have the strength and wisdom and humanity to create/deliver effective solutions. This	Experto credite	This is obvious too. It's a huge opportunity. There's a hidden army of millions of 'lived experience' people, covering every possible entry to suicidal ideation.

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
		guide, advise, support, innovate etc.	helps everyone – strugglers and those beginning to struggle - and teaches those yet to struggle (including most professionals) what's actually required.		We must make use of this resource.
3	HM Prison and Probation Service	Suicide prevention partnerships – what an effective partnership looks like and how it can work best in a prison setting?			
4	LGA	Key area for quality improvement 3 **Primary care involvement**	While there are examples of strong partnerships with primary care across local suicide prevention planning, this is not always consistently the case.	Strengthen involvement of primary care in local suicide prevention partnerships. Further guidance that captures and shares where this works well would be beneficial.	
5	National Suicide Prevention Alliance	Key area for quality improvement 1: Better inclusion of and support for people with lived experience in suicide prevention partnerships	NICE guidance (1.1.3) recommends including people with personal experience of a suicide attempt, suicidal thoughts and feelings, or a suicide bereavement in multi-agency partnership. The Government strategy also encourages their inclusion, as does Public Health England's (PHE) 2016 Local suicide prevention planning, a practical resource24. However, there is limited information on how to do this effectively and safely.	In October we ran 4 workshops across the country with people who have lived experience, and it was clear that there was interest in and enthusiasm for being involved in suicide prevention policy and practice. However, the people we spoke to were aware that it is important to provide training, a support structure, and appropriate resources (such as paying for travel) to enable a broad range of people with lived experience to get involved. These may also support multi-agency groups to better engage	Anecdotal evidence from our workshops – we could share our findings if helpful.

[24] http://www.nspa.org.uk/wp-content/uploads/2016/10/PHE_LA_guidance-NB241016.pdf

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
			The NSPA agrees with PHE about the value of involving people affected by suicide: "bringing personal experience to create a more complete picture of suicide and suicide prevention; helping to identify issues that clinicians and commissioners might not be aware of; highlighting gaps between policy and practice; and helping to ensure work is grounded in the reality of the impact of suicide and self-harm." However, it is vital that there is appropriate training and support for those with lived experience, to ensure they are able to use their experiences in ways that are safe for themselves and others.	representatives with lived experience from wider at-risk groups, such as the LGBT community or men in low income groups. A national programme of training and support for people with personal experience of suicidal thoughts or behaviours and those bereaved by suicide could minimise the risk of duplication across government strategies and interventions and improve integration across suicide prevention.	
6	NCD	**Children & young people**	Based on our national study of suicide in under 20s, the recent NatCen survey & policy work such as the Children's Green Paper. Key standards would be on collaboration between NHS & schools/universities; self-harm services; the CAMHS-adult transition; online safety.		http://documents.manchester.ac.uk/display.aspx?DocID=37566
7	North West Boroughs Healthcare NHS Foundation Trust	Key area for quality improvement 1 Trusts should have a Suicide Prevention Strategy , signed up by board	Many trusts have suicide prevention strategic group but these are led by professionals who are interested in the field but there may be no buy in from the exec with regards to implementing the quality improvement indices and usually leads to repeated exercise of lessons learnt dissemination	As per NICE Guidance evidence review , also anecdotally , board support for suicide prevention groups is not pronounced in local and neighbouring trusts	As for previous columns

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
8	SCM1	Key area for quality improvement 1 **Ensure there is an effective multi-agency partnership for suicide prevention which has a suicide prevention plan to co-ordinate activities and resources**	From evidence reviewed to inform the development of the NICE guidelines on suicide prevention it is clear that suicide cannot be addressed by any one agency in isolation and must have a multi-agency approach to promote effectiveness.	This provides a framework to ensure the co-ordination of suicide prevention activities and to ensure the effectiveness of activities to maximise outcomes for recipients of these services. This also provides an opportunity for linkage between custody and community.	• Public Health England (2016) Local suicide prevention planning • • Public Health England (2016) Support after a suicide: A guide to providing local services • Public Health England (2015) Identifying and responding to suicide clusters and contagion • Public Health England (2015) Preventing suicides in public places • • The All-Party Parliamentary Group (APPG) on Suicide and Self-Harm Prevention (2015) Inquiry into Local Suicide Prevention Plans in England
9	SCM2	4.Suicide prevention partnerships	Suicide can only be prevented at population level through effective multi-agency working where expertise, resources and intelligence are shared towards a common goal. Clear, robust governance arrangements must be in place to hold partnerships to account and to ensure that there is sufficient influence at strategic level within those partnerships to direct scarce resources and funding towards suicide prevention activity.	Partnerships require strategic oversight and governance from statutory services linked to the population health agenda such as Health and Well Being Boards. Public Health teams within local authorities have responsibility for co-ordinating suicide prevention plans but there is currently no funding allocated. In order for suicide prevention to be prioritised by all relevant partners there must be organisational representation on partnerships at sufficiently senior level to have influence in relation to	4.Suicide prevention partnerships

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
				competing priorities. Suicide prevention is multifaceted so partnerships require the expertise of a various of stakeholders including those with lived experience. It is not possible for Public Health practitioners to lead on all strands of a strategy or plan and so partnerships must have representation from people with specific expertise, interest and influence within their respective organisations.	
10	SCM3	Suicide prevention partnerships	These are a key component of local suicide prevention. Effective suicide prevention will require co-ordinated multi-sectoral action	The composition of these groups and functioning of these groups is likely to be highly variable across the country	Local Authority Guidance for suicide prevention and NICE guideline
11	SCM5	Key area for quality improvement 1 **Robust multi-agency partnerships and strategies on suicide prevention, both in the community and in custodial settings**	There is some evidence that having in place partnership arrangements that encourage information sharing and collaborative working has a positive impact. Many local agencies in communities and custodial settings are involved in suicide prevention. Such partnerships also encourage involvement from those with lived experience and give a platform for their voices to be heard. Strategies setting out how to connect local agencies and interested persons which have clear leadership and aims helps to focus resource on activities most likely to result in positive outcomes and promote the use of data and sharing of best practice.	The national suicide prevention strategies set out requirements for local authorities to have suicide prevention partnerships. Areas for quality improvement include: • Ensuring local authorities have responded to this ask, • Ensure clear leadership and direction, • Ensure clear aims and terms of reference, • Ensure representation of core partners, including relevant custodial settings in Local Authority partnerships (and vice versa where necessary)	

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				• Ensure voices of those with lived experience are included • Ensure strategies are in place and well publicised to relevant agencies and individuals	
12	The Samaritans	Area for quality improvement 2: **Improved lived experience consultation and representation of at risk groups**	NICE guidance recommends including the following representatives in multi-agency partnerships: people with personal experience of a suicide attempt, suicidal thoughts and feelings, or a suicide bereavement - to be selected according to local protocols. However, there is limited information on how to do this effectively and safely. Samaritans strongly believes it is important that there's a stronger input from people with personal experience of suicidal thoughts – and a forum to do this through. This is critical for ensuring services are designed in a person-centred way to reach the most at-risk groups. This would add significant value locally, harnessing expertise and capacity to inform and engage with suicide prevention activity. It is vital that there is appropriate training and support for those with lived experience, to ensure they are able to use their experiences in ways that are safe for themselves and others.	Through the National Suicide Prevention Alliance (NSPA), we've been involved with workshops across the country with people who have lived experience over the last few months. Through feedback from these workshops it's clear there is a need and demand from the public to establish a national programme for people with personal experience of suicidal thoughts to engage in local development and delivery. It's also clear current mechanisms for engaging people with lived experience need strengthening. Additionally, more needs to be done engage representatives with lived experience from wider at-risk groups, such as the LGBT community or men in low income groups. This would minimise the risk of duplication across government strategies and interventions and improve integration across suicide prevention. A national programme of training and support for people with personal experience of suicidal thoughts or	Anecdotal evidence through the NSPA workshops.

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				behaviours and those bereaved by suicide could minimise the risk of duplication across government strategies and interventions and improve integration across suicide prevention.	
Partnership working – Intelligence-based strategy and action plan					
13	Festival of Life and Death	Key area for quality improvement 1 Workplace measurement of suicides, suicide attempts, and staff suicide ideation.	If you cannot measure it you cannot manage it.	This is an accepted principle of management.	
14	INQUEST	Additional developmental areas of emergent practice	A formal review of the Record of Inquests and Prevention of Future Death reports compiled by coroners would provide valuable evidence to help inform their thinking		
15	LGA	Key area for quality improvement 1 **Real-time data**	Access to real-time attempted suicide and self-harm data is very challenging to collect. This would further help to tailor local interventions to prevent suicide, identify people who might be at risk and respond to possible patterns.	Development of real-time attempted suicide and self-harm data. This would involve working with councils, coroners, policy, health and other partners. Sharing of data and safeguarding would need to be appropriately considered.	
16	National Suicide Prevention Alliance	Key area for quality improvement 2: Increased use of real-time suicide surveillance data	NICE guidance (1.4.3) and PHE's guidance both state the importance of real-time suicide surveillance data or 'rapid intelligence gathering' to better enable the identification of deaths by suicide in order to better identify emerging methods and potential clusters, and to provide support for the	Our understanding, from our work with PHE and the Support After Suicide Partnership (SASP) along with other member organisations, is that there has been limited implementation of real-time surveillance, or more rapid intelligence gathering.	Thames Valley's Resource Pack on NSPA site Outcomes of PHE project

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			bereaved, all of which play a crucial role in preventing further deaths by suicide. This requires close working between police, coroners and public health. A practical example of the benefits is reported in Thames Valley Police's Resource Pack25,: - Successfully captured all suicides from November 2015 to date. - Enabled identification and analysis of trends and patterns related to potential linked cases/ clusters. - Developed the ability to cross-check data with Coroner Teams on a regular basis which has assisted with data validation. - Systematically shared timely information with public health suicide prevention leads in order to enable proactive action to be taken to prevent suicide. - Enabled co-ordinated swift response to identified cases of contagion and clusters through the TV-SPIN.	PHE are currently undertaking a project to find out whether a coronial (and police) led real time suicide surveillance system would lead to earlier, more effective monitoring and improved support for people bereaved by suicide, and what action is required to implement a real time suicide surveillance system across the UK effectively. The findings of this work, and other learning should be widely shared – for example Thames Valley Police's Resource Pack and information from a workshop26 identify some key learning points and challenges: - Responsiveness of local authority suicide prevention/public health leads and other relevant stakeholders is critical to its success. - Postvention work including bereavement support is reliant on local funding arrangements. - Partners involved in the [Thames Valley project] must ensure they have dedicated resources and adequate capacity in order to process and act on intelligence being generated by the system	

[25] http://www.nspa.org.uk/wp-content/uploads/2018/07/Thames-Valley-Real-time-Suicide-Surveillance-pack.pdf

[26] NSPA (2018) How to set up and run a real-time suicide surveillance system? http://www.nspa.org.uk/wp-content/uploads/2018/02/How-to-set-up-and-run-a-real-time-suicide-surveillance-system1.pdf

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			- Enabled timely bereavement support though Cruse Bereavement Support Service. - Helped identify Suicide Prevention Champions in several organisations through local partnership work.	- Gaps in Bereavement Support i.e. wider network of those affected (Friends, Work Colleagues) - Assimilating attempt suicide or self-harm data	
17	North West Boroughs Healthcare NHS Foundation Trust	Key area for quality improvement 2 Trusts should develop Suicide Prevention action plans with multiagency partnerships especially Coroner and Prison	The same services within the trust / same teams may account for most of the suicide figures and this may be true for public health services and primary care services as well, There are frequent self-harm repeaters who are subject to numerous MHA act assessments or repeatedly present at high risk spots but the care remains disjointed and is never wrapped around their needs	The communication across systems has a lot to be desired and is ineffective, with cross sectional assessments leading to different outcomes for the high risk group of patients and soon services build barriers for repeat presenters across police/security/mental health services. There is no overarching risk formulation or management	NCISH publications, NICE evidence summary, CQUiNs on the topic
18	PHE	Local Suicide Prevention Planning	To improve local suicide prevention and planning and, in turn, better support those in crisis and those bereaved by suicide	1.Introduction of 'Real Time Data' – effective and capacity to offer post attempt/suicide support 2.Timely Access to care - clear pathways and transitions (ensure connected systems i.e. 'tell us once') 3. Mapping of journey/intervention points to reduce suicides 4. reduce stigma – open talking/promotion 5. Embed in sustainability and transformation plans and Local Authority plans, for example a standard template to ensure consistency with local additions.	Public Health England and the National Suicide Prevention Alliance jointly published Local Suicide Prevention Planning: a practice resource, available to view here: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/585411/PHE_local_suicide_prevention_planning_practice_resource.pdf

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19	PHE	Custodial settings	Improved suicide prevention planning and leadership in custodial settings	All detained settings have individual multiagency suicide prevention plan with clear leadership; governance structures including annual review, SMART objectives and links to local authority plans.	NICE Guideline: Preventing suicide in community and custodial settings https://www.nice.org.uk/guidance/ng105/resources/preventing-suicide-in-community-and-custodial-settings-pdf-66141539632069
20	Royal College of General Practitioners	Key area for quality improvement 5	Timely data and evidence to improve responses and services presented in easily understood infographics and dashboards	Required to measure impact	
21	Royal College of Paediatrics and Child Health	Ensure suicides in young people ('teen suicides') receive defined mention in these standards	There is a lot of work going on around the country in suicide prevention, but data collection and analysis seems not to recognise the special issues around the (escalating) numbers of teen suicides. There is one report from Manchester:  cyp_2017_full-report .pdf	There are special factors at play in suicide in young people, and suicide prevention programmes need to reflect this.	The PHE guidance listed in the topic overview key documents does make brief reference to schools and colleges (p40 -41) Published data are scanty, and mostly North American (Ploeg J, Ciliska D, Dobbins M, Hayward S, Thomas H, Underwood J (1996). A systematic overview of adolescent suicide prevention programs. *Canadian Journal of Public Health* 87(5): 319-324. Also, Gould M, Kleinman MH, Lake AM, Forman J, Midle JB. The role of newspaper coverage in the initiation of teenage suicide clusters. *Lancet Psychiatry* 2014; **1**: 34-43
22	SCM1	**Key area for quality improvement 2** Collate and analyse local data on suicide	In order to ensure the most appropriate suicide prevention services and activities are planned and co-ordinated	By understanding the needs of the community consideration can be given to ensuing the activities and support	• Public Health England (2016) Local suicide prevention planning •

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		and self-harm which includes rapid intelligence gathering to identify suspected suicides, emerging methods and potential	for communities it is important to understand the needs of the individuals within those local communities.	services planned for suicide prevention meet the needs of the community which they are designed to serve and support. In addition by accessing rapid intelligence data there is an opportunity to recognise emerging suicide prevention cluster and activate interventions which may prevent further deaths.	• Public Health England (2016) Support after a suicide: A guide to providing local services • Public Health England (2015) Identifying and responding to suicide clusters and contagion • The All-Party Parliamentary Group (APPG) on Suicide and Self-Harm Prevention (2015) Inquiry into Local Suicide Prevention Plans in England
23	SCM2	3.Gathering and analysing suicide –related information	Up to date local information and intelligence in relation to demographics, raised risk groups emerging trends and prior contact with services is vital to enable services to work collaboratively to enable the most relevant organisation(s) to change policies and procedures or training strategies to mitigate risk on both a 'population' and individual level. Suicide prevention involves problem solving and this cannot take place without comprehensive, accurate intelligence contributed by all organisations which hold relevant information.	Many organisations hold information and intelligence in relation to suicide risk in relation to specific individuals and to wider sub-population groups. This information and intelligence is generally not shared between partners because of concerns regarding confidentiality and GDRP legislation. Existing multi-agency real-time surveillance arrangements, where they exist, usually only related to incidents of (suspected) suicide rather than including suicide attempts or medically serious self harm episodes. Similarly audits of coroners' files are limited in their effectiveness due to the time lag between death and inquest and inquest and file review and because coroners' files do not contain all the information needed for a full	3.Gathering and analysing suicide –related information

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				intelligence picture of a suicide (Coroners are not charged with investigating 'why' the deceased took their own life). Organisations including mental health trusts and GP practices often conduct internal investigations into a death or serious incident which are not shared in a multi-agency setting until an inquest. Rapid multi-agency pre-inquest reviews of incidents could provide vital intelligence in relation to risk and gaps in services whilst also identifying people in need of postvention support.	
24	SCM3	Suicide prevention plans	Key element of local delivery. Nationally mandated	Most areas now have plans but they are variable.	APPG audit of suicide prevention plans; Local Authority Guidance on developing plans (due to be updated by PHE and NPSA shortly). Note that PHE/National delivery group are scrutinising plans and will be able to input into any proposed QS
25	SCM3	Responding to clusters/dealing with the media	Better practice in these areas may prevent imitative suicide/ further deaths	Unclear to what extent local areas have action plans in place to address these issues and what the content of these plans might be.	There is relevant PHE guidance. Also the recent Papyrus/Universities UK guidance on dealing with student suicide may be relevant.
26	SCM4	Key area for quality improvement 2	Gather 'real time' information about local suicides to identify and manage clusters.	Suicide clusters will not be identified by the information gathered by coroners after an inquest. Information needs to be gathered by the police and the coroners to give early identification of clusters.	

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27	SCM4	Key area for quality improvement 5	Ensure that each authority has a multi-agency strategy in place	There is a requirement to have a local strategy in place, but evidence suggests they are not. There should be an audit to ensure compliance.	
28	SCM5	Key area for quality improvement 2 **Collection and analysis of real-time data on suicide and self-harm; ensuring that findings are reflected in strategy**	We have found particularly in custodial settings that where prisons have a good understanding of their data, particularly in terms of self-harm (as the quantity of data is far greater), there is in turn a greater understanding of the underlying issues causing distress and raising risk. Where this is linked to the ongoing safety strategy local issues can be addressed. Understanding the profile of those at risk is key in terms of making defensible decisions around the care and support offered to individuals. Use of all available information sources ensures the picture of an individual is complete. Understanding real-time data allows for early identification of clusters and any trends in terms of underlying stressors, method etc. and ensures that robust measures are put in place by the multi-agency partnerships to address the issues.	Data collection and use varies across different local authority areas and custodial settings. There is a lack of consistency in the use and understanding of data; as well as procedures to ensure effective information sharing. Multi-agency partnerships in community and custodial settings should have the following in place: • An understanding of the data available • Strong information sharing protocols with relevant agencies to ensure ease of access to required data • Staff trained to extract, analyse and report on data • Dedicated time to review trends and make recommendation on strategy (for example data working groups or sub-committees) • Evidence that their strategy reflects the local data picture • Measures in place to ensure fast response to urgent emerging issues (e.g. clusters)	

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29	SCM6	Suicide prevention action plans in residential, custodial and detention settings		There is guidance around developing local authority suicide prevention plans, however, there is less guidance to ensure that suicide prevention plans in residential, custodial and detention settings. Quality standards in this respect would therefore be helpful.	
30	The Office of the Chief Allied Health Professions Officer- NHS England	Key area for quality improvement 1	NG105 section 1.4	Collecting and acting on local data	
31	The Samaritans	Area for quality improvement 5: **Increased real-time suicide surveillance and local data collection**	National suicide data offers a helpful starting point to establish the macro picture and to enable comparisons with the England average and upper and lower quartile rates. Important sources include the Office for National Statistics and the Public Health Outcomes Framework. The PHE Suicide Prevention Profile is recommended as the foundation tool to gather data and analysis on local populations, risk factors and contact with health services, including benchmarking against other similar local areas and national indicators. There are however limitations to the information that can be gained about a local area through the national data. Local data provides an opportunity to gather additional information.	Multi-agency partnerships decisions about the scope, timing and frequency of local data collection work are likely to be determined by the resources available, particularly lack of public health funding. And this work is also dependent on co-operation of partners, for example the coroners or police. There have been numerous trials of real-time surveillance across local areas, however a national evaluation is required, and support is needed to enable and improve surveillance at local levels. Learnings from across local areas need to be shared. For instance, Thames Valley Police identify the following challenges from their trial of real-time surveillance: • Co-operation across agencies is required to get the data	Anecdotal evidence from multi-agency partnerships

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			Real-time suicide surveillance, also known as real time data, is a system that enables the public health team and/or the multi-agency suicide prevention group to consider and agree if interventions are required after a death has occurred where the circumstances suggest suicide in advance of the coroners' conclusion. The system can provide the means to offer timely support to people who have been bereaved or affected by a suspected suicide and to respond quickly to emerging patterns that could indicate clusters, increasing trends or new methods of death. NICE guidance, PHE guidance for local areas and national strategies all reinforce the importance of local data collection and real-time suicide surveillance.[27] [28]	• Not all bereaved relatives require support especially if they have issues with an agency e.g mental health service providers • Preventative activity requires a cross-community approach and not just monitoring at risk locations • Gaps in Bereavement Support i.e. wider network of those affected (Friends, Work Colleagues) • Assimilating attempt suicide or self-harm data[29]	
Awareness and communication - Awareness raising					
32	Body & Soul	Additional developmental areas of emergent practice Training (for wider population, and those working with people at risk of suicide)	There is a growing body of evidence of the impact that adverse experiences in the childhood can have on people's mental and physical health and wellbeing through their lifetime. Understanding the impact of trauma on mental health and as a correlation and adopting a trauma informed care	Individual programmes and support are often not based on the correlation between childhood adversity and presenting outcomes, and lack an understanding of suicide as a symptom of a previous traumatic experience rather than an illness would streamline approaches to support, and offer	The Adverse Childhood Study (Fellitti and Anda, 1998) found that people who experienced 4 or more ACEs (adverse childhood experiences) had a 4-12 times increased the risk of suicide compared to peers who had 0 ACEs.

[27] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/585411/PHE_local_suicide_prevention_planning_practice_resource.pdf
[28] NHS England (2016) Five Year forward View for Mental Health https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf
[29] NSPA (2018) How to set up and run a real-time suicide surveillance system? http://www.nspa.org.uk/wp-content/uploads/2018/02/How-to-set-up-and-run-a-real-time-suicide-surveillance-system1.pdf

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			approach, understanding suicide as a symptom of trauma, could significantly improve the prevention and support for those affected by suicide and suicidal ideation.	opportunities for early intervention and prevention	1. Choi, N. G., Dinitto, D. M., Marti, C. N., & Segal, S. P. (2017). Adverse childhood experiences and suicide attempts among those with mental and substance use disorders. Child Abuse & Neglect, 69, 252–262. 2. 3. The effect of multiple adverse childhood experiences on health: a systematic review and meta-analysis (Hughes et al, 2017) found here: https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667%2817%2930118-4/fulltext 4. Associations of adverse childhood experiences and suicidal behaviors in adulthood in a U.S. nationally representative sample (Thompson, Kingree and Lamis, 2018). Found here: https://onlinelibrary.wiley.com/doi/abs/10.1111/cch.12617
33	College of Mental Health Pharmacy (CMHP)	Evidence based public health campaigns are required.	It is essential that all campaigns are evidence based and monitored.	It is vital that we practice evidence based approaches. By documenting this, we can learn from our actions in years to come and other nations can learn from us.	
34	Derbyshire Healthcare NHS Foundation Trust	Suicide prevention strategy groups/ local Public Health engagement with large	NICE quality standard 1.5.6 To promote the importance of suicide prevention being everybody's business. Work place settings can	Evidence from Skanska and others has highlighted in their workplace and community guidance, that major	http://www.nspa.org.uk/members/skanska-uk-plc/ Vignettes in:

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		businesses within the community to promote suicide prevention in the workplace e.g Reducing the risk of suicide: A toolkit for employers and Crisis management in the event of a suicide: A postvention toolkit for employers	have an impact on those who are vulnerable, as well as providing support if a suicide occurs in their setting.	employers have demonstrated the importance of such an approach.	Reducing the risk of suicide: A toolkit for employers: https://wellbeing.bitc.org.uk/all-resources/toolkits/suicide-prevention-toolkit and Crisis management in the event of a suicide: A postvention toolkit for employers: https://wellbeing.bitc.org.uk/sites/default/files/business_in_the_community_crisis_management_in_the_event_of_a_suicide_toolkit.pdf
35	Festival of Life and Death	Key area for quality improvement 3 Educate and empower communities.	Traditional methods and treatments mostly fail. 75% of suicides are outside treatment/known at risk people. It will take 30 years to change the NHS and current systems.	Current assumptions and solutions are based on systems/infrastructures that mostly do not work for suicide prevention. We must me radically creative.	This is obvious.
36	Festival of Life and Death	Key area for quality improvement 4 Introduce suicide education and prevention properly into schools. Start at infants school.	Suicide is so dangerous because it is hidden. Children understand death if it's explained to them carefully. If we hide it from children we increase risks. We teach children very young that fire is dangerous. So we must teach them about the risk of suicide.	It is grossly stupid and reckless to think we must protect children from suicide by not teaching them about it.	This is counter-intuitive and scary, but entirely logical when we consider it rationally, not emotionally.

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37	National Suicide Prevention Alliance	Key area for quality improvement 5: More national support and guidance on effective communications around suicide	NICE guidance (1.5) emphasises the need for awareness raising by suicide prevention partnerships. This can help to reduce stigma, encourage help-seeking, raise awareness of how to recognise and respond to someone at risk of suicide, and share information on the support available locally and nationally. It is particularly important to reach those at higher risk of suicide.	At a national level, more needs to be done to support local areas to communicate around suicide prevention and reach the most at risk communities. Across STP's plans there are a wide range of community-based initiatives that involve elements of awareness raising, tackling stigma and encouraging help-seeking. National communication resources would prevent duplication of efforts at a local level and ensure consistency of messages.	Anecdotal evidence from multi---agency partnerships and NSPA members.
38	NCD	**Middle-aged men**	The main issue here is about access to help, esp in primary care - important report from Samaritans on this & other factors. Standards would therefore cover measures taken locally to help men overcome shame & stigma; efforts to reach male environments/workplaces; collaboration (esp with charities) on male health eg through sport; online access.		https://www.samaritans.org/about-us/our-research/research-report-men-suicide-and-society
39	Royal College of General Practitioners	Key area for quality improvement 2	Greater public awareness and united action across the community. Local support and community prevention plan across the lifespan. Reducing access to means of self-harm	Enabling men to ask other men about their mental health	
40	Royal College of General Practitioners	Key area for quality improvement 3	Shared responsibility across government, private and non-government sectors to build mentally healthy workplaces.	Healthy work places are essential to suicide prevention	Evidence from Western Australia https://www.mhc.wa.gov.au/about-us/strategic-direction/suicide-prevention-2020-together-we-can-save-lives/

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41	SCM5	Key area for quality improvement 3 **Awareness raising in communities (including custodial settings) to reduce stigma and encourage help-seeking**	Stigma and myths around suicide is still a huge issue, both in community and custodial settings. It is a barrier to help seeking both for those with suicidal ideation, and those who have been bereaved or affected by suicide; and acts as a barrier for intervention. Ensuring local awareness raising addresses these issues and focuses on giving clear information dispelling myths, tackling stigma and providing practical tips on how and where to seek help could have a big impact.	We know that many people that take their own lives have not had contact with GP services or mental health teams prior to their death. Similarly, in prisons we know that many people that die by suicide were not being supported by suicide prevention plans at the time of their death. Stigma discourages people from seeking help when they need it. Studies have found that suicide survivors experience stigma in the form of shame, blame, and avoidance. Suicide survivors showed higher levels of stigma than natural death survivors. Stigma was linked to concealment of the death, social withdrawal, reduced psychological and somatic functioning, and grief difficulties. Research looking at those caring for suicidal individuals suggest that their needs are not being addressed. Similarly support for those bereaved or affected by suicide is not consistent. In custodial settings, trauma support systems for staff caring for those with suicidal behaviour and those involved in incidents where someone has taken their own life are not sufficient. (Links to improvement 5)	The Stigma of Suicide Survivorship and Related Consequences—A Systematic Review
42	The Office of the Chief Allied Health	Key area for quality improvement 2	NG105 1.5	Tackling stigma amongst health care professionals and the public though targeted awareness raising	HEE have produce the following suicide and self-harm competencies for adults, children

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	Professions Officer- NHS England				and young people and public health which would be applicable to AHPs: https://www.hee.nhs.uk/our-work/mental-health/self-harm-suicide-prevention-frameworks
43	The Office of the Chief Allied Health Professions Officer- NHS England	Key area for quality improvement 4	NG 105, 1.6.3	Improving awareness of, and access to, services that people can get help from when they feel unable to cope	Inclusion of AHPS working with people affected by suicide in the development of action plans and specifically paramedics
44	The Samaritans	Area for quality improvement 4: **More national support is needed on effective communications and media guidelines**	NICE guidance emphasises the need for awareness raising by suicide prevention partnerships. It specifies local partnerships should consider local activities to: • raise community awareness of the scale and impact of suicide and self-harm • reduce the stigma around suicide and self-harm • address common misconceptions by emphasising that: ○ suicide is not inevitable and can be prevented ○ asking someone about suicidal thoughts does not increase risk • make people aware of the support available nationally and locally	At a national level, more needs to be done to support local areas to communicate around suicide prevention and reach the most at risk communities. Across STP's plans there are a huge amount of community-based initiatives that involve elements of awareness raising, tackling stigma and encouraging help-seeking. National communication resources would prevent duplication of efforts at a local level and ensure that these aren't developed in isolation. It would also ensure appropriate, safe and effective messaging is used, in line with messaging recommended in the Samaritans' media guidelines. National communication resources should be developed based on consumer insight and evidence from existing suicide prevention and stigma reducing campaigns (e.g. Small Talk	Anecdotal evidence from multi-agency partnerships and Samaritans' branches

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			• encourage help-seeking behaviours • encourage communities to recognise and respond to a suicide risk. It states, these activities should take into account socioeconomic deprivation, disability, physical and mental health status, and cultural, religious and social norms about suicide and help-seeking behaviour, particularly among groups at high suicide risk.	Saves Lives, Freecall, Time to Change), this would ensure an effective, efficient and joined up approach is taken to public information provision on suicide prevention. Samaritans is providing support to some local multi-agency groups, particularly those with high frequency locations on how to communicate when there is an attempt/suicide in a public place. Evidence shows the importance of responsible media reporting but with new communication channels, it's critical that everyone communicates responsibly.	
Awareness and communication – Media communication					
45	National Suicide Prevention Alliance	More national support and guidance on effective communications around suicide	It is also vital that people are aware of the risks around media reporting of suicide, as per NICE guidance 1.10, due to the potential for harmful effects. With the range of new communication channels, however, it is critical that everyone communicates responsibly.	It would also ensure appropriate, safe and effective messaging is used, in line with messaging recommended in the Samaritans' media guidelines30.	
46	SCM4	Key area for quality improvement 4	Ensure multi-agency partners has someone to lead of the responsible media reporting of suicide.	We know that responsible reporting of suicide without glamorising or describing the means is important in preventing suicide.	
Reducing access to methods of suicide					
47	INQUEST	Key area for quality improvement 2	Higher minimum levels of skilled, qualified staff on specialist wards, including increased capacity for one to	Identified as a common failure contributing to the circumstances	Evidence arising from INQUEST casework with families following deaths of in-patients in mental

[30] http://www.nspa.org.uk/resources/media-guidelines-for-reporting-suicide/

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			one therapeutic care. Stopping the overuse of poorly trained, unqualified agency staff.	surrounding the death of mental health in patients.	health hospitals. Evidence also in Records of Inquest and Prevention of Future Death reports arising from these cases.
48	NHS Improvement	Removal of ligature points to prevent suicide	There have been misinterpretations and/or misunderstandings of the existing guidance and a lack of awareness of alternative equipment (eg tap designs that do not create a ligature point). The Care Quality Commission (CQC) has also revised its inspectors' guide for the same reason.	Following the death of a patient using a ligature attached to low-level taps in a bathroom, a subsequent Coroner's Regulation 28 report highlighted that there was confusion over how ligature points should be assessed, and their removal prioritised. This Alert is not new guidance it aims to clarify existing guidance and emphasises the importance of considering multiple factors in assessing the risk posed by ligature points.	Please see NHS Estates and Facilities Alert Assessment of ligature points. Please note it was not put in the public domain so as to not give people ideas. Only people that have a CAS login would be able to see it via the link once they have logged in https://www.cas.mhra.gov.uk/ViewandAcknowledgment/ViewAlert.aspx?AlertID=102797
49	NCD	**Frequently used locations**	Based on reviews of research published in journals & PHE guidance Standards would be on prevention through assessing environmental risk; data monitoring to identify locations; physical measures/barriers; availability of crisis support at locations; working with local media.		https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/481224/Preventing_suicides_in_public_places.pdf
50	NCD	**Specialist mental health care**	Based on the evidence of the national confidential inquiry, in particular the "10 ways to improve safety" that have come out of studies relating changes in service configuration to patient suicide rates in the UK. Standards would cover ward safety, early follow up on hospital discharge,		https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(16)00063-8/fulltext

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			specialist services working with substance misuse patients, etc.		
51	North West Boroughs Healthcare NHS Foundation Trust	Key area for quality improvement 5	Reduce prescription rates for opioids in liaison with primary care.	Pain management services and interventions again operate on piece meal approach and interface and impact on mental health services /interventions is not taken into account. Prescription rates of Opioid medications especially for patients with mental health illness who may have altered perception of pain and present frequently to primary care are likely to be disproportionately high and increase the risk of suicide.	NICE evidence summary
52	Royal College of General Practitioners	Key area for quality improvement 2 Prescribing of psychotropic medications and opiate medication in primary care	Being prescribed more than one type of drug was associated with an 11-fold increase in suicide risk.	Suicide in primary care _ National Confidential Inquiry into Suicide and Homicide by People with Mental Illness , March 2014	
53	Royal College of Psychiatrists	Key area for quality improvement 2	Prevention of suicide in people with chronic physical health problems There is good evidence people with chronic physical health problems have an increased risk of suicide with this risk being especially high in some groups such as those with chronic pain. Opiate based analgesia is an increasingly common cause of	Current suicide prevention guidelines in the UK do not target this high-risk group. Reasons for association with suicide are not fully understood and only partly explained by depression.	Record linkage showed death by suicide in England and wales was more common after general hospital admission for gastrointestinal reasons (Roberts et al. Psychological Medicine. 2018 Mar; 48(4): 578–591). Record linkage in UK showed those who died by suicide were 3.1 times more frequently last discharged from general than from psychiatric hospitals; and

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			completed suicide and is also increasingly being prescribed.		only 14% of those discharged from a general hospital had a recorded psychiatric diagnosis at last visit. Dougall et al (2014) BJPsych Volume 204, Issue 4 April 2014, pp. 267-273 A government 'think tank' Demos (2011) produced a report showing One in 10 suicides are linked to chronic physical illness, with an average of one suicide per day in the UK The UK GP databased was used by the Suicide Research prevention centre (2012) to find risk of suicide in physical illness was especially high in women and the risk was only partly explained by depression.
54	SCM1	**Key area for quality improvement 3** Support activities to reduce access the suicide methods to include identifying emerging trends in suicide methods and locations **5.**	From research available indications are that reducing access to suicide methods can impact on suicide rates. Easy access to suicide method is particularly important when considering suicides which maybe more impulsive in nature.	6. It is important to look at the availability of suicide method as part of any multi-agency partnership work to look at how methods of suicide in local communities might potentially be mitigated. This includes identify emerging trends in suicide methods and locations, understanding local	• Public Health England (2016) Local suicide prevention planning • Public Health England (2015) Identifying and responding to suicide clusters and contagion

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				characteristics that may influence the methods used, determining when to take action to reduce access to the means of suicide	
People at risk – Identifying people at risk					
55	INQUEST	Key area for quality improvement 3	Ensuring 'big picture' risk assessments are conducted that properly reflect a person's known history and risk triggers, as opposed to snapshot / responsive decision making and assessments. Information sharing and communication given highest priority within 'big picture' assessments and understanding.	Identified as a common failure contributing to the circumstances surrounding the death of mental health in patients.	Evidence arising from INQUEST casework with families following deaths of in-patients in mental health hospitals. Evidence also in Records of Inquest and Prevention of Future Death reports arising from these cases.
56	INQUEST	Key area for quality improvement 4	Better staff training to ensure proper working knowledge and application of key policies for risk assessment and safe care and management of patients and environments.	Identified as a common failure contributing to the circumstances surrounding the death of mental health in patients.	Evidence arising from INQUEST casework with families following deaths of in-patients in mental health hospitals. Evidence also in Records of Inquest and Prevention of Future Death reports arising from these cases.
57	LGA	Key area for quality improvement 4 **Self-harm in a community setting**	Existing guidance on self-harm focusses more on clinical settings, but local areas are also seeking to reduce rates in community settings and understand the links between self-harm and suicide.	Development of further guidance on identification and prevention of self-harm in a community setting. This would help to further drive service improvement and share knowledge.	
58	National Suicide Prevention Alliance	Key area for quality improvement 3: Improved training for primary care practitioners	We know that one third of people who end their lives by suicide are in contact with their GP in the month preceding their death, but are not receiving	The RCGP note that many GPs have not received formal training in self-harm and suicidal ideation and that the barriers to receiving this include	Health Education England have published new competency frameworks for practitioners -

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		in signs and symptoms, treatment pathways, and the National Consensus Statement on 'Information sharing and suicide prevention'	specialist mental health services.31 This suggests primary care practitioners could play a critical role in identifying and supporting people who are at risk of suicide and that current referrals from GPs to specialist mental health services for people at risk of suicide aren't adequate. Training of primary care physicians in depression recognition and treatment, has been identified as one of the most effective interventions in lowering suicide rates.32 The Royal College of General Practitioners (RCGP) believes that "there is a certainly a role for general practice and wider primary care to play in identifying and reacting to suicide risk"33 and reports that current suicide prevention training models have successfully improved skills and been well-received by GPs and staff. Also, self-harm is the strongest indicator of future suicide risk, and the NICE guidance on self-harm emphasises the critical role GPs play	current training models being "quite intensive, lengthy and inflexible," making access impractical for overstretched GPs with heavy workloads. More flexible approaches could include greater use of online resources. A CQC report found that one in four people experiencing a mental health crisis said they did not feel they could get help they needed from their GP. GPs have a vital role in identifying mental health issues. When they do not feel they can provide the required care they must refer people to specialist services, such as talking therapies.35 A report from the Royal College of Psychiatrists lists numerous barriers that are preventing GPs delivering this compassionate care – including lack of training and lack of skilled workforce.36 The General Medical Council should ensure that all undergraduate medical students receive training in the assessment of suicide risk as well as	www.hee.nhs.uk/our-work/mental-health/self-harm-suicide-prevention-frameworks

[31] National Confidential Inquiry into Suicide and Safety – Annual Report 2018 - https://www.hqip.org.uk/resource/national-confidential-inquiry-into-suicide-and-safety-annual-report-2018/#.W-6LVHv7SUk
[32] Zalsman et al, 2016
[33] Written evidence provided by RCGP to the Health Select Committee, 11th October 2016 http://www.parliament.uk/business/committees/committees-a-z/commons-select/health-committee/inquiries/parliament-2015/suicide-prevention-inquiry/publications/
[35] CQC (2015) Right here, right now https://www.cqc.org.uk/sites/default/files/20150611_righthere_mhcrisiscare_summary_3.pdf
[36] Royal College of Psychiatrists (2015) Compassion in care: ten things you can do to make adifference https://www.rcpsych.ac.uk/pdf/FR-GAP-02_Compassionate-care.pdf

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			in supporting people who have self-harmed. Additionally, in 2014, the Department of Health published a Consensus Statement on 'Information sharing and suicide prevention'34 to support healthcare professionals decide when to inform family and friends about someone at risk of suicide, as they can be vital to support and recovery.	depression and self-harm and that the assessment of depression and suicide risk should be included in the examinations for GPs. Training should also include the existence and content of the Consensus statement.	
59	North West Boroughs Healthcare NHS Foundation Trust	Key area for quality improvement 4 Provide Training packages to train professionals across all levels who work with patients at risk of suicide	There is huge gap in training needs And training received by health professionals on suicide prevention especially on risk formulation with services across the spectrum public to mental health relying on risk prediction as an outcome of risk assessment by checklist tools , in spite of overwhelming evidence against same practice	In absence of a systemic approach to understanding of risk and suicide prevention piece meal interventions based on risk prediction which is less than 5% accurate leads to ineffective interventions. Moreover, this has allowed to commissioning of one service at the cost of other although that condition may be overrepresented in suicide population for example dual diagnosis and substance use services being reduced and being separated from mental health services.	Evidence is provided by NCISH reports and publications
60	PHE	Gambling & Suicide	There has been an increased focus on gambling related suicides recently, but the data and research on the topic is limited.	Better data and research to drive awareness and intervention planning	
61	Royal College of General Practitioners	Key area for quality improvement 1	Coordinated and targeted responses for high risk groups.	The high risk groups are often socially isolated and need proactive care	Asking about suicide ideation in high risk groups in all contacts with health services https://www.gov.uk/government/p

[34] http://www.nspa.org.uk/wp-content/uploads/2018/05/Consensus_statement_on_information_sharing.pdf

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					ublications/suicide-prevention-third-annual-report
62	Royal College of General Practitioners	Key area for quality improvement 3 Targeted screening for depression	A targeted screening approach. There are a number of factors that are known to increase the risk of suicide for example long-term physical health problems, self- harming, drug and alcohol misuse, a past suicide attempt, a family history of suicide, a diagnosis of a personality disorder and current and past mental health problems, particularly in patient treatment.	J Affect Disord. 2015 Nov 15;187:151-5. doi: 10.1016/j.jad.2015.08.029. Epub 2015 Aug 25. Comorbid depression and alcohol use disorders and prospective risk for suicide attempt in the year following inpatient hospitalization. Britton PC, Stephens B, Wu J et al.	
63	Royal College of General Practitioners	Key area for quality improvement 4	Increased suicide prevention training.	As well as the general public, many health and social care professionals are uncomfortable discussing suicide ideation and the protective and risk factors	In the US, the National Action Alliance for Suicide Prevention has put forth the Zero Suicide (ZS) Model, a framework to coordinate a multilevel approach to implementing evidence-based practices. The Assess, Intervene and Monitor for Suicide Prevention model (AIM-SP) is a guide for implementation of ZS evidence-based and best practices in clinical settings. https://doi.org/10.3389/fpsyt.2018.00033
64	Royal College of General Practitioners	Additional developmental areas of emergent practice	Counselling women starting oral contraceptives and suicide risk which peaks at 2 months	Hormonal contraception use in Denmark doubled the risk of suicide attempt and triples the risk of suicide	Skovlund CW, Mørch LS, Kessing LV, et al. (2018) Association of hormonal contraception with suicide attempts and suicides. Am J Psychiatry **175**(4):336–342

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65	Royal College of Nursing	Key area for quality improvement 1 Identification and vigilance	We think it is vital that staff have core skills to recognise and support those who are feeling suicidal or thinking about suicide.	Our recent work with nurses suggests that many lack confidence to have a conversation with someone who is suicidal. We think it is important for all healthcare staff to be able to recognise and hold a conversation with someone about their suicidal thoughts and ideas.	This is consistent with the zero-suicide initiative https://www.zerosuicidealliance.com
66	Royal College of Psychiatrists	Key area for quality improvement 2	Prevention of suicide in people with chronic physical health problems There is good evidence people with chronic physical health problems have an increased risk of suicide with this risk being especially high in some groups such as those with chronic pain. Physical health professionals lack skills in assessing and managing suicide risk despite being responsible for a high-risk population.	Current suicide prevention guidelines in the UK do not target this high-risk group. Reasons for association with suicide are not fully understood and only partly explained by depression.	Record linkage showed death by suicide in England and wales was more common after general hospital admission for gastrointestinal reasons (Roberts et al. Psychological Medicine. 2018 Mar; 48(4): 578–591). Record linkage in UK showed those who died by suicide were 3.1 times more frequently last discharged from general than from psychiatric hospitals; and only 14% of those discharged from a general hospital had a recorded psychiatric diagnosis at last visit. Dougall et al (2014) BJPsych Volume 204, Issue 4 April 2014, pp. 267-273 A government ‘think tank’ Demos (2011) produced a report showing One in 10 suicides are linked to chronic physical illness, with an

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					average of one suicide per day in the UK The UK GP databased was used by the Suicide Research prevention centre (2012) to find risk of suicide in physical illness was especially high in women and the risk was only partly explained by depression.
67	Royal College of Psychiatrists	Key area for quality improvement 1	A focus on older adults/older persons above the age of 65 as recent evidence confirms that older adults are at a higher risk of completed suicide and yet are least likely to be recognised as suffering from mental disorder or referred to secondary mental health services	The proportion of older people and numbers of older people in the population is increasing, and this includes the numbers of older people suffering from mental disorder.	This pattern is further confirmed by a recent study that suggests old people who self-harm are less likely to be referred to specialist mental health services than younger adults, despite a higher risk of suicide in this group (Morgan C, et al 2018). Morgan C, Webb R, Carr M, *et al.* Self-harm in a primary care cohort of older people: incidence, clinical management and risk of suicide and other causes of death Lancet Psychiatry (2018 Two leading figures in old age psychiatry quote similarly alarming statistics. Among the facts listed by Alistair Burns and James Warner (Burns & James, 2015) are that 85% of older people with depression receive no help from the NHS and that older people are a fifth as likely as

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					younger age groups to have access to talking therapies but six times as likely to be on medication. Burns, A. & James, W., 2015. *Better Access to Mental Health Services for Older People.* [Online
68	SCM1	Key area for quality improvement 4 Ensure that training by suicide prevention partnerships is available in communities	In order to most effectively support individuals at risk of suicide individuals need to have access to training to identify those who might be at risk and how best to meet the support needs of those individuals and should address training for specialist and non-specialists in order to maximise opportunities for interventions.	Whilst there might already be training available on suicide prevention there maybe issues in relation to communities ability to access training but also in the consistency of content being covered as part of the training. In some areas there may not currently be training available. Training more individuals to recognise risk and undertake intervention may impact positively on deaths by suicide.	The All-Party Parliamentary Group (APPG) on Suicide and Self-Harm Prevention (2015) Inquiry into Local Suicide Prevention Plans in England Public Health England (2016) Local suicide prevention planning
69	SCM2	5. Awareness raising by Suicide Prevention Partnerships	There is a need to encourage people who have suicidal thoughts, particularly those with a plan and intent to seek help. Stigma associated with mental ill-health and particularly suicidal thoughts can be a barrier to help-seeking, as can lack of general awareness of the availability of support. It's important that front line staff are able to discuss suicide in ways which do not perpetuate stigma. An individual thinking of suicide may need specific support in relation to an intervention and may also need services which can alleviate or mitigate particular life stresses such as	There are many services and initiatives available nationally and in particular localities which can contribute to suicide prevention. Often other front line services are not aware of the availability of such services. In the absence of dedicated funding for suicide prevention an 'asset based' approach needs to be taken and this means linking up all relevant services and ensuring that staff-and people who are at risk-know what bespoke services are available to them, within what time frame and how they can be accessed. Providing commissioned or 3rd sector services opportunities to	5. Awareness raising by Suicide Prevention Partnerships

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			bereavement, debt, relationship breakdown or acute/long term health conditions. It is important that gatekeepers in contact with someone at risk or who discloses suicidal intent are able to help that person devise a safety plan which includes access to relevant, credible and accessible services which can offer hope and help them address causes of their distress.	raise awareness of their availability and how they are able to address actual or perceived gaps in provision is really important. This can be done through specific marketing, conferences, workshops or other events aimed at raising awareness and networking.	
70	SCM2	1. Training and awareness raising amongst the staff of front line services in relation to suicide prevention and the impact of suicide	Very few front line professionals including clinicians receive formal suicide prevention training. It is vitally important for people who encounter individuals who may be contemplating suicide in order that they have the confidence to ask if someone is thinking about suicide, disrupt/ interval in their plan, keep the person safe ,reduce access to the means agree a meaningful,co-produced safety plan. There is also a need for training in relation to bereavement through suicide which can improve the response and therefore the support for people who have lost a loved one who present to health professionals.	Delivery of training across statutory and other services is under significant pressure as a result of very limited budgets. Lack of awareness and low levels of confidence amongst front line professionals in relation to suicidal ideation and the impact of bereavement through suicide can cost lives. There are many training topics which are 'competing' for the attention of front line services which must be prioritised. Many of these topics are indirectly related to suicide prevention and are worthy additions to organisational training strategies (e.g. LGBTQ, autism, drug and alcohol brief advice, safeguarding , Mental Health First). Aid, Prevent/ACT). Evidence based suicide prevention training can not only improve communication between a care provider/gatekeeper and someone at risk, it can also improve the self-awareness and recognition of front line professionals and volunteers who may themselves	• Training and awareness raising amongst the staff of front line services in relation to suicide prevention and the impact of suicide

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				experience mental ill-health or suicidal thoughts , particularly in identified raised risk occupations.	
71	SCM5	Key area for quality improvement 4 Improve access to high quality training on suicide prevention for key individuals (see 1.7.1 of guideline)	Whilst awareness raising across the general population is important, it is equally important to ensure that those individuals identified as working with at risk groups, working in locations known to be high risk and gatekeepers have more formalised training around suicide prevention. Improving knowledge around suicide, it's risks and methods of prevention ensures that those people most likely to encounter suicidal people are equipped to offer support and signpost to appropriate intervention.	Provision of suicide prevention training is inconsistent currently. There has been significant work undertaken in prisons in England and Wales over the last 18 months to improve quality and consistency of training in suicide and self-harm prevention for all staff, with more specific training for key groups; however, this has yet to be evaluated, and thus the impact is currently unknown. What can be said is that suicide rates dropped in prisons in the 12 months to December 2017, however as a wide range of interventions were introduces in this period alongside improved training it is not possible to draw firm conclusions around impact. Research on suicide prevention training in the UK is limited, as are the specialised training programmes available. However, what is available suggests there are benefits to ensuring the right people receive generic and specific suicide prevention training depending on their circumstances (e.g. custodial settings). Benefits include equipping people with the knowledge, skills and confidence to intervene; therefore, increasing the likelihood they will act.	

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72	SCM5	Additional developmental areas of emergent practice			There is some useful information around emerging practice on suicide prevention training here
73	SCM5	Additional evidence sources for consideration	There isn't much very recent research on suicide in UK prisons, however Manchester university are currently undertaking research looking a suicide prevention tools in prisons in England and Wales. There was a recent publication in the Lancet about prison suicide more widely which highlighted the reduction of prison suicides in Scotland, linking it to changes in the drug treatment strategy in prisons. The study emphasised the importance of understanding and addressing individual risk factors, rather than prison level risk factors and the need for more sensitive markers for healthcare needs of those in custody. http://research.bmh.manchester.ac.uk/cmhs/research/centreforsuicideprevention/suicideinprisons/ https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(17)30430-3/fulltext		
74	The Samaritans	Area for quality improvement 3: **Improved training for primary care**	While suicide prevention is often seen as an issue that relates mainly to mental health services, fewer than 30% of people who die by suicide in England were in contact with mental	We know that one third of people who end their lives by suicide are in contact with their GP in the month preceding their death, but are not receiving specialist mental health services.[41]	Health Education England have published new competency frameworks for practitioners - https://www.hee.nhs.uk/our-

[41] National Confidential Inquiry into Suicide and Safety – Annual Report 2018 - https://www.hqip.org.uk/resource/national-confidential-inquiry-into-suicide-and-safety-annual-report-2018/#.W-6LVHv7SUk

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		practitioners in signs and symptoms and treatment pathways	health services in the 12 months prior to their death.[37] A proactive community-based response, supported by responsive primary care services is therefore required in addition to effective mental health services. Training of primary care physicians in depression recognition and treatment, has been identified as one of the most effective interventions in lowering suicide rates.[38] The Royal College of General Practitioners (RCGP) believes that *"there is a certainly a role for general practice and wider primary care to play in identifying and reacting to suicide risk"*[39] and reports that current suicide prevention training models have successfully improved skills and been well-received by GPs and staff. Therefore the General Medical Council should ensure that all undergraduate medical students receive training in the assessment of suicide risk as well as depression and self-harm and that the assessment of depression and suicide risk should be included in the examinations for GPs.	This suggests primary care practitioners could play a critical role in identifying and supporting people who are at risk of suicide and that current referrals from GPs to specialist mental health services for people at risk of suicide aren't adequate. The RCGP note that many GPs have not received formal training in self-harm and suicidal ideation and that the barriers to receiving this include current training models being *"quite intensive, lengthy and inflexible,"* making access impractical for overstretched GPs with heavy workloads. More flexible approaches could include greater use of online resources. A CQC report found that one in four people experiencing a mental health crisis said they did not feel they could get help they needed from their GP. GPs have a vital role in identifying mental health issues. When they do not feel they can provide the required care they must refer people to specialist services, such as talking	work/mental-health/self-harm-suicide-prevention-frameworks

[37] *National Confidential Inquiry into Suicide and Homicide by People with Mental Illness*, University of Manchester (2016) http://research.bmh.manchester.ac.uk/cmhs/research/centreforsuicideprevention/nci/reports/2016-report.pdf

[38] Zalsman et al, 2016

[39] Written evidence provided by RCGP to the Health Select Committee, 11th ctober 2016 http://www.parliament.uk/business/committees/committees-a-z/commons-select/health-committee/inquiries/parliament-2015/suicide-prevention-inquiry/publications/

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			Self-harm is the strongest indicator of future suicide risk, and the NICE quality standards on self-harm emphasise the need for compassion, respect and dignity from healthcare practitioners in assessments. The NICE guidance on self-harm emphasises the critical role GPs play in supporting people who have self-harmed. Additionally, in 2014, the Department of Health published a Consensus Statement on 'Information sharing and suicide prevention'[40] to support healthcare professionals decide when to inform family and friends about someone at risk of suicide, as they can be vital to support and recovery.	therapies.[42] A report from the Royal College of Psychiatrists lists numerous barriers that are preventing GPs delivering this compassionate care – including lack of training and lack of skilled workforce.[43] Training should also include the existence and content of the Consensus statement.	
People at risk – Support for people at risk					
75	Body & Soul	Key area for quality improvement 1 Partnership Working/Timely referrals to partnership agencies.	Early intervention and partnership working can reduce the likelihood of individuals going on to a completed suicide.	Individuals who have attempted suicide are at increased risk of attempting suicide again in the future, with 1 in 4 suicides occurring by those already in touch with mental health services. Clinical assessments indicate that individuals have attempted suicide multiple times before being referred to appropriate support.	Research indicates that the strongest predictor for future suicide risk is one or more prior suicide attempts. Yoshimasu & Kiyohara (2008). Suicidal risk factors and completed suicide: meta-analyses based on psychological autopsy studies. Healthcare Quality Improvement Partnership (2017). National Confidential Inquiry into Suicide

[40] http://www.nspa.org.uk/wp-content/uploads/2018/05/Consensus_statement_on_information_sharing.pdf
[42] CQC (2015) Right here, right now https://www.cqc.org.uk/sites/default/files/20150611_righthere_mhcrisiscare_summary_3.pdf
[43] Royal College of Psychiatrists (2015) Compassion in care: ten things you can do to make adifference https://www.rcpsych.ac.uk/pdf/FR-GAP-02_Compassionate-care.pdf

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					and Homicide by People with Mental Illness. Available at: http://documents.manchester.ac.uk/display.aspx?DocID=37560
76	Body & Soul	Key area for quality improvement 2 Meaningful activities & non-clinical interventions	Increasing life meaning and purpose reduces the risk of suicide, developing a sense of identity and connection within a community.	The quality of support for individuals who are suicidal and/or have attempted suicide focuses heavily on clinical interventions such as short-term risk management, medication and psychological therapy.	Camden and Islington NHS trust conducted research on the impact of meaningful activity with individuals with mental health problems. https://www.ndti.org.uk/uploads/files/MH_research_on_meaningful_activity.pdf Research suggests that purpose in life mediates between satisfaction with life and suicidal ideation. https://link.springer.com/article/10.1023%2FB%3AJOBA.0000013660.22413.e0
77	Body & Soul	Key area for quality improvement 4 Peer Support	Young people in particular are more likely to talk to friends, family and informal sources over professionals when discussing their mental health.	There is a lack of availability of peer-led support, particularly for young people who have previously attempted suicide.	Mayor (2018). Peer support reduces hospital readmissions for mental health crises. https://doi.org/10.1136/bmj.k3405
78	Derbyshire Healthcare NHS Foundation Trust	Suicide Prevention Training (including training around suicide bereavement) provided routinely for key staffing groups including, but not limited to Mental Health Trust Staff, primary care staff,	There is good evidence that training can lead to significant improvements in suicide prevention. Suicide prevention training is recommended in the draft NICE guidelines for suicide prevention in community and custodial settings.	The lack of routinely provided suicide prevention training (either during initial/pre-registration training or throughout employment) is acknowledged by professional clinical bodies, charities and patients alike. But the degree to which there is a lack of training needs to be quantified.	Isaac, M., Elias, B., Katz, L. Y., Belik, S. L., Deane, F. P., Enns, M. W., ... & Swampy Cree Suicide Prevention Team (12 members) 8. (2009). Gatekeeper training as a preventative intervention for suicide: a systematic review. The Canadian Journal of Psychiatry, 54(4), 260-268.

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		Prison Staff and Social Service staff.	One of our service user representatives has shared that training needs to incorporate the importance of exploring familial relationships /wider support networks with an individual at risk of suicide and the voices of those bereaved (to share the impact losing a loved one has had on them, but perhaps more importantly, how they would have felt if their loved one had shared how they were feeling with them). – as this is what helped him at a time of crisis.	Royal College of Nursing quoted in Nursing Times: https://www.nursingtimes.net/news/education/call-for-suicide-prevention-training-to-become-standard-for-all-nurses/7024554.article	Hayes, A. J., Shaw, J. J., Lever-Green, G., Parker, D., & Gask, L. (2008). Improvements to suicide prevention training for prison staff in England and Wales. Suicide and Life-Threatening Behavior, 38(6), 708-713.
79	HM Prison and Probation Service	Interventions and support for men and women in prison custody who are at risk of suicide.			
80	INQUEST	Additional developmental areas of emergent practice	Greater access to one to one therapeutic care		
81	Parkinson's UK	Ready access to liaison psychiatry for all Parkinson's outpatient clinics.	There are several points at which patients with Parkinson's are at their most vulnerable in the outpatient departments to suicidal ideation. Attempted suicide in people with Parkinson's has been associated with a history of impulsive control disorder (Voon, V et al (2008) 'multicentre study on suicide outcomes following subthalamic stimulation for Parkinson's disease' Brain, 131, 2720-2728).	Access to liaison psychiatry for Parkinson's outpatient clinics is an area in need of quality improvement in respect to suicide prevention. There is a commitment to all acute hospitals having access to all-age liaison mental health services by 2020/21 in the Mental Health Five Year Forward View (MH FYFV) (NHS England 2016 'Mental health Five Year Forward View') and this commitment is cited as a key part of the government's 'Preventing Suicide in England'	

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			There are also cases of people with Parkinson's following the surgical procedure of deep brain stimulation that have experienced a decline in mood and increased levels of apathy and a related heightened suicide risk (Foley, J (2018) 'Standardised Neuropsychological Assessment for the Selection of Patients Undergoing DBS for Parkinson's Disease," Parkinson's Disease, vol. 2018, Article ID 4328371).	strategy (HM Government (2017) Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives). The MH FYFV also states that there is a shortage of liaison mental health in hospitals. The UCL 'Self-harm and Suicide Prevention Competence Framework for work with adults and older adults' identifies that a transition from a service unable to manage suicidal ideation presents a potential increased risk that should be managed. We have heard from neuropsychologists of cases where they have not had access to liaison services due to staff shortage, and patients referred to A&E with suicidal intent have left hospital before being seen due to the long waits. A clear example of where quick access to liaison psychiatry is needed, and therefore an area for quality improvement.	
82	Royal College of Nursing	Key area for quality improvement 2 **Safety planning**	We would like to see improvements in skills to develop safety planning for people who are suicidal.	Training in recent years has focused on the development of safety plans for people e.g. Connecting with People which links a compassionate based approach to the development of a safety plan. Training in NHS organisations is not consistent with many using varying models most focusing on risk	This is consistent with the current prominent training approaches - STORM training, ASIST Training and Connecting with People and Zero Suicide Training. [Accessed 23rd November 2018]

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				management rather than safety planning.	
83	Royal College of Nursing	Key area for quality improvement 4 **Referral and Support systems**	We believe there is a need to actively link people up to practical and psychological support to manage suicidal thoughts, feelings and ideas. This should include crisis line numbers.	We want services e.g. primary care and IAPT to become more community aware and know how to facilitate access to vital support services. We also want commissioners of services (within both health and the local authority) to ensure their communities have good support systems, networks and places of refuge where people can receive practical and psychological support. Interagency role in earlier prevention should be part of a standard pathway.	Some examples http://www.maytree.org.uk https://www.mind.org.uk/information-support/guides-to-support-and-services/crisis-services/crisis-houses/#.W_aYpKecZQI https://hectorshouse.org.uk http://listeningplace.org.uk/ http://jwsmf.org/james-place/ https://www.thematthewelvidgetrust.com
84	Warrington Borough Council, Public Health Team on behalf of Local Suicide Prevention Partnership Board	Appropriate referral to non-clinical services to address wider determinants/social issues that are risk factors for suicide	We know that there are a number of risk factors associated with suicide that are not part of a clinical need e.g. debt, housing. If an individual can be supported with their wider needs may reduce suicide risk.	Varying referral to non-clinical services from primary care. Important that there is a consistent offer of wider support/social prescribing.	Certain stressful life events can play a part in increasing the risk of an individual dying by suicide. These include: • The loss of a job; • Debt; • Living alone, becoming socially excluded or isolated; • Bereavement; • Family breakdown and conflict including divorce and family mental health problems; • Imprisonment. (HM Government, 2012, 2015 and 2017) National research has identified a number of stressful situations which can increase the risk of suicide. Of these, the stressful situation most frequently seen amongst the cohort of people included in the Warrington

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					audit were living alone (19 out of 49), and unemployment (12 out of 49)
People at risk – Information sharing					
85	Derbyshire Healthcare NHS Foundation Trust	Routine standard information sharing regarding suicidal behaviour, suicidal ideation and risk with community agencies (e.g. primary care, probation) following discharge from prison	There is good evidence that prisoners are at high risk of suicide within the first two weeks of release from prison. Yet communication between Prison settings and community based healthcare providers is poor.	Communication around suicide risk between/with healthcare institutions is poor. This is despite the Crisis Care Concordat intended to clarify just reasons for data sharing. Communication was a main area identified for improvement by the recent analysis of NHS resolution data, relating to suicide deaths 2. “there needs to be systematic approach to communication which ensures that important information regarding an individual is shared with appropriate parties”	Binswanger, I. A., Stern, M. F., Deyo, R. A., Heagerty, P. J., Cheadle, A., Elmore, J. G., & Koepsell, T. D. (2007). Release from prison—a high risk of death for former inmates. New England Journal of Medicine, 356(2), 157-165. Oates et al., 2018 Learning from Suicide-related claims. A thematic Review of NHS Resolution Data, Accessible via: https://resolution.nhs.uk/resources/learning-from-suicide-related-claims/
86	HM Prison and Probation Service	Information sharing – how can we ensure that the right people have the right information to make decisions about individuals at risk?			
87	HM Prison and Probation Service	Engaging with the families of people at risk – how can we appropriately share information, and work in partnership, with the			

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		families of those at risk?			
88	INQUEST	Key area for quality improvement 1	Improved communication and information sharing between mental health staff and family/carers. Necessary for the fullest possible picture / assessment / safe management of risk, including in the grant of home leave. Recognising that 'confidentiality' should not be used as an obstruction and must be held in working balance around the preservation of life.	Identified as a common failure contributing to the circumstances surrounding the death of mental health in patients.	Evidence arising from INQUEST casework with families following deaths of in-patients in mental health hospitals. Evidence also in Records of Inquest and Prevention of Future Death reports arising from these cases.
89	PHE	Allied Health Professionals	Better training and support for Allied Health Professionals around suicide prevention	Training is offered to all staff to raise awareness of suicide prevention including adoption of a trauma informed approach. Working collaboratively with people who may be at risk to develop 'safety planning' • Person centred rather than protocol centred • Sharing information with families, carers and significant others where possible • Managing transitions between services Organisations provide and promote services to support staff who may be considering taking their life Postvention – signposting to resources for people bereaved by suicide e.g.	Health Education England and the National Collaborating Centre for Mental Health published a series of self-harm and suicide prevention frameworks: https://www.hee.nhs.uk/our-work/mental-health/self-harm-suicide-prevention-frameworks

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				Help is at Hand: http://supportaftersuicide.org.uk/support-guides/help-is-at-hand/	
90	Royal College of General Practitioners	Key area for quality improvement 5 Ensure continuity of care through information sharing	Promote excellent continuity of care by transmitting patient health information to emergency care and psychology services to create seamless pathways. Be aware of the Consensus statement on information sharing and the Mental Capacity Act. If a patient consents to information being shared with family members or friends, utilise these people as an additional resource to keep the person safe.	Information sharing and suicide prevention. Consensus statement. Prepared by Mental Health, Equality and Disability Division. DH 2014	
91	Royal College of Nursing	Key area for quality improvement 3 **Sharing information**	We believe that there is a need to develop a standard to enable staff to share in an appropriate and timely way with others about suicide risk e.g. with families, which we believe may save lives. This should include common communication systems across teams and agencies.	Serious incidents processes often highlight communication problems in supporting a person who is suicidal including system and message failures not helped by many teams and agencies being on different IT systems. Confidentiality is also often cited as a reason not to communicate. Standards on communication are needed	UK Government (2014) Information sharing and suicide prevention: consensus statement. Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/271792/Consensus_statement_on_information_sharing.pdf [accessed 22/11/2018]
Supporting people bereaved or affected by a suspected suicide					
92	Body & Soul	Key area for quality improvement 5 Support for those bereaved	Those affected by suicide bereavement are more likely to go on and take their own life and there are several difficult and unique emotional responses that arise because of bereavement by suicide.	The awareness and understanding of the impact of suicide and the need for focused and specialist support for family and friends is not consistent among practitioners and wider society. Pathways to such support is also patchy within local suicide prevention strategies.	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3384446/ Research demonstrates the complicated grief that loved one's experience as a result of bereavement by suicide.

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93	Derbyshire Healthcare NHS Foundation Trust	Number of people bereaved by suicide given Help is at Hand –	NICE quality standard 1.8.2 Recommended that those bereaved by suicide receive "Help is at hand" booklet and receive it early. It should be routinely given by first responders and any service who has early contact with those bereaved e.g. police, ambulance, A&E, Coroner's office, undertakers.	There is substantial unmet need for those who are bereaved by suicide. All areas should have a cross community approach to ensuring Help is at Hand is being given out. - Local and National audits in key settings e.g. Coroners, MH trusts, Police coordinated through Public Health led Suicide Prevention Strategy groups.	Dyregrov K. What Do We Know About Needs for Help After Suicide in Different Parts of the World? Crisis. 2011 6;32(6):310-8 http://cebmh.warne.ox.ac.uk/csr/EvaluationReport.pdf
94	HM Prison and Probation Service	Bereavement support for staff and families of people who die in custody.			
95	LGA	Key area for quality improvement 2 **Bereavement support**	There are different approaches to commissioning bereavement support, usually from the voluntary and community sector, and there is an appetite to get better at sharing this.	Further good practice guidance on models for commissioning bereavement support, including scope for scaling up existing services.	
96	National Suicide Prevention Alliance	Key area for quality improvement 4: Improved support for those bereaved by suicide	NICE guidance (1.8) recommends offering support to those who are bereaved and recommends signposting to PHE's Help is at Hand guide. Likewise, the national suicide prevention strategy recommends better support for those bereaved or affected by suicide. Around 6,500 people die by suicide each year across the United Kingdom and Republic of Ireland, with each of these deaths likely to cause intense grief and emotional distress to those	Anecdotal evidence from our members suggests there is a lot of variation in consistency, structure and access to bereavement services across the UK. Services are not always tailored to the specific needs of someone bereaved by suicide. Also, due to the variable use of real-time suicide surveillance (as above, and as recommended in the NICE guidance 1.8.1), support is often not offered as quickly as would be useful to those bereaved.	Various localised studies have been carried out that demonstrate inconsistency in bereavement services, however a national audit of suicide bereavement services is not available.

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			closest to the person who has died such as parents, siblings, partners and friends, and often also having an impact on the wider community. Recent research suggests up to 135 people are affected by each death by suicide44. The emotions experienced after bereavement by suicide can differ considerably from other types of death, the shock can be especially acute and complex, and there are additional processes to go through, including the inquest. There is evidence that people who have been bereaved by suicide can themselves be at a higher risk of suicide45.	• Avoiding practices that could inadvertently cause harm must be an important aim of providing services to people who have been bereaved by suicide and so service providers and commissioners should follow existing PHE/NSPA guidance 'Support after Suicide: A guide to providing local services'46. Help is it at Hand received generally positive feedback, but we understand that many people bereaved by suicide are unaware of it and are not signposted to it by services that they come into contact with. Coroner's offices are particularly well placed to do this, and SASP are also raising awareness of Help is at Hand among funeral directors. Better support around the inquest process could also be beneficial, and so more widespread use of the Coroners' Courts Support Services (who provide practical and emotional support to bereaved families) could also be valuable.	
97	NCD	**Bereavement support**	Less research in this field but increasing experience.		https://uksobs.org/

[44] Cerel, J. , Brown, M. M., Maple, M. , Singleton, M. , Venne, J. , Moore, M. and Flaherty, C. (2018), How Many People Are Exposed to Suicide? Not Six. Suicide Life Threat Behav. . doi:10.1111/sltb.12450
[45] http://discovery.ucl.ac.uk/1476423/
[46] http://www.nspa.org.uk/wp-content/uploads/2017/01/PHE_postvention_resource-NB311016.pdf

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			Standards would be on early offer of support; high quality information; support available locally; input from bereaved families themselves.		
98	North West Boroughs Healthcare NHS Foundation Trust	Key area for quality improvement 3 Have processes in place to offer support to family members bereaved by suicide	The support currently offered by services is perfunctory and doesn't consider impact of bereavement by suicide on the survivors especially delayed presentation	There are very few services who involve the survivors in the whole cycle of SIRI , lessons learned and only deal on a communication exercise level with the named carer, oblivious to other family members /carers needs	NICE evidence summary, publications related to Patient safety Incident Management System
99	Royal College of General Practitioners	Key area for quality improvement 1 Provision of bereavement support for families by GPs	Bereavement by suicide is a risk factor for suicide GPs described mental health as 'part and parcel' of primary care, but disclosed low confidence in dealing with suicide and an unpreparedness to face parents bereaved by suicide. Some GPs described guilt surrounding the suicide, and a reluctance to initiate contact with the bereaved parents.	BJGP 2016 Oct; 66(651): e737–e746. GPs' experiences of dealing with parents bereaved by suicide: a qualitative study Foggin et al.	
100	Royal College of Nursing	Key area for quality improvement 5 **Support for carers, staff and others affected by suicide**	We believe that more can be done to ensure those affected by suicide are supported.	We want NHS organisations to actively link relatives, carers, staff and friends up to support systems for those affected by suicide.	Work of Survivors of Bereavement (SoBS) https://uksobs.org which has a range of resources and materials Help is at hand - resource for people bereaved by suicide and other sudden, traumatic death. Available from: http://supportaftersuicide.org.uk/support-guides/help-is-at-hand/

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101	SCM1	**Key area for quality improvement 5** **Ensure that any individual bereaved by suspected suicide is identified in order that appropriate tailored support can be provided**	Evidence suggests individuals bereaved by suicide are at elevated risk of taking their own lives.	Currently, there does not appear to be consistency on how individuals who are bereaved by suicide are identified and supported. Effective early identification and tailored support may assist in reducing distress of those bereaved by suicide who may consider ending their own lives. This action is also relevant for looking to identify and engage in early intervention for possible emerging suspected suicide clusters.	• • House of Commons Health Committee (2017) Suicide prevention • Public Health England (2016) Local suicide prevention planning • Public Health England (2016) Support after a suicide: A guide to providing local services • Public Health England (2015) Identifying and responding to suicide clusters and contagion • The All-Party Parliamentary Group (APPG) on Suicide and Self-Harm Prevention (2015) Inquiry into Local Suicide Prevention Plans in England • Department of Health and Social Care (2012) Preventing suicide in England: A cross-government outcomes strategy to save lives
102	SCM2	2. Improved support for people bereaved or affected by suicide	The emotional impact of a death through suicide on families, colleagues first responders and many others is associated with the deceased is known to be significant with long term health and wellbeing implications. Research	Formal suicide postvention services are the best way of providing support alongside other 3rd sector provision and as a result mitigating further risk of mental ill-health and suicide. People bereaved through suicide are best	• Improved support for people bereaved or affected by suicide

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			also shows that those directly bereaved through suicide are at greater risk of later suicide themselves. Identifying those at risk generally across the population is very difficult and yet the section of the community bereaved through suicide and therefore at increased risk is identifiable and largely evident to local services.	supported by those with a shared experience and with specific training in relation to suicide bereavement. Postvention services are additionally able to provide or enhance real time surveillance of suicide in areas where other arrangements don't exist or where it is limited. This has implications in relation to early identification of an emerging suicide cluster where a rapid , multi-agency response is required to prevent further loss of life. Formal postvention support arrangements are in place in a minority of localities across the country effectively creating post-code lottery for people who are bereaved or otherwise affected by suicide and who, as a result , are some of the most vulnerable people in society.	
103	SCM3	Helping people bereaved by suicide	Bereavement by suicide is extremely distressing and is itself associated with higher suicide risk	Many areas will not provide bereavement support services. There are third sector providers (eg SOBS) but coverage is not uniform and interventions (e.g group based may not be suitable for everyone)	See Local authority guidance for providing services and implementation guide
104	SCM4	Key area for quality improvement 3	Support for Bereaved people	As someone who has lost a child to suicide, and I often meet with parents who have also lost someone to suicide, I know there is no support for those recently bereaved by suicide. This is serious omission not to support those who are at an increased risk of suicide.	

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105	SCM5	Key area for quality improvement 5 **Improve support offered to people bereaved and affected by suicide**	Bereavement by suicide is one of the most complex and difficult to overcome. We also know that the effect of suicide goes far more widely that those close to the individual that died. Trauma caused by someone's suicide can affect a range of people, including family and friends, those who lived and worked closely with the person, those who witnessed the incident and those involved in the immediate aftermath (e.g. emergency staff and custodial staff).	There is evidence to suggest that those who have been bereaved or affected by suicide are at increased risk of suicide themselves, particularly young adults. There is also evidence that those caring for suicidal individuals suggest that their needs are not being addressed. Similarly support for those bereaved or affected by suicide is not consistent. In custodial settings, trauma support systems for staff caring for those with suicidal behaviour and those involved in incidents where someone has taken their own life are not sufficient.	The Stigma of Suicide Survivorship and Related Consequences—A Systematic Review Bereavement by suicide as a risk factor for suicide attempt: a cross-sectional national UK-wide study of 3432 young bereaved adults
106	SCM6	How suicide prevention partnerships can support people bereaved or affected by suicide	People bereaved by suicide or affected by a suspected suicide may be at risk of harming themselves. This includes family members and friends of people who have died, as well as first responders.	There are a range of different suicide bereavement models, from signposting to a local SOBs to a proactive bereavement support using real time surveillance. Bereavement support may also include practical as well as emotional support and clear quality standards for what should be provided would be helpful.	
107	The Office of the Chief Allied Health Professions Officer- NHS England	Key area for quality improvement 5	NG105 1.8	Ensuring comprehensive postvention services for families affected by suicide	
108	The Samaritans	Area for quality improvement 1:	Around 6,500 people die by suicide each year across the United Kingdom and Republic of Ireland, with each of	Anecdotal evidence suggests there is a lot of variation in consistency, structure and access to bereavement	Various localised studies have been carried out that demonstrate inconsistency in bereavement

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		Improved access to bereavement services and support in local areas	these deaths likely to cause intense grief and emotional distress to those closest to the person who has died such as parents, siblings, partners and friends, but often also having an impact on the wider community. The emotions experienced after bereavement by suicide can differ considerably from other types of death, the shock can be especially acute and complex. There is also evidence that people who have been bereaved by suicide can themselves be at a higher risk of suicide. NICE guidance recommends offering support to those who are bereaved and recommends signposting to PHE's *Help is at hand* guide. Likewise, the national suicide prevention strategy recommends better support for those bereaved or affected by suicide.	services across the UK. Additionally, services are not always tailored to the specific needs of someone bereaved by suicide. Also, due to the variable use of real-time suicide surveillance (as above, and as recommended in the NICE guidance 1.8.1), support is often not offered as quickly as would be useful to those bereaved. • • Avoiding practices that could inadvertently cause harm must be an important aim of providing services to people who have been bereaved by suicide and so service providers and commissioners should follow existing PHE/NSPA guidance 'Support after Suicide: A guide to providing local services'[47]. Feedback to Samaritans on the content of the *Help is it at Hand* guide has generally been positive although a frequently raised concern is that many people bereaved by suicide are unaware of the resource and are not signposted to it by services that they come into contact with. There are various potential 'gatekeepers', such as coroners during the inquest process, who are likely to come into contact with people who have recently been bereaved by suicide and could	services, however a national audit of suicide bereavement services is not available.

[47] http://www.nspa.org.uk/wp-content/uploads/2017/01/PHE_postvention_resource-NB311016.pdf

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				provide support. This could include signposting them to Help is at Hand. Better support around the inquest process would be beneficial, and so more widespread use of the Coroners' Courts Support Services (who provide practical and emotional support to bereaved families) could also be valuable.	
109	Warrington Borough Council, Public Health Team on behalf of Local Suicide Prevention Partnership Board	Appropriate referral to suicide postvention support for anyone affected or exposed to suicide	We know that people affected or exposed to suicide are 6 times more likely to take their own life	Commissioning of suicide postvention support varies greatly nationally. However, it is important that where services do exist people are effectively signposted/referred.	Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives (2017) highlighted the importance of improving responses to suicide bereavement and improving support services. It has been identified that those affected or exposed to suicide are at greater risk of taking their own life.
Additional areas – Training and skills					
110	College of Mental Health Pharmacy (CMHP)	Align this standard with National Collaborating centre for mental health/NHS HEE/UCL self-harm and suicide prevention competence framework.	It is essential that all expectations and standards are aligned for all organisations including pharmacy teams to best understand their role and contribution.	It enables all stakeholders to best understand their role and contribution. It will also enable improved measurement of efficacy, something that is lacking (see comment 2)	
111	Royal College of General Practitioners	Key area for quality improvement 4	Other approaches that need further investigation include gatekeeper training, education of physicians, and internet and helpline support. Many GPs have reported that they had not	Review | October 26, 2005. Suicide Prevention StrategiesJAMA. 2005;294(16):2064-2074. doi:10.1001/jama.294.16.2064. A	

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		GP education on suicide prevention and depression	received formal training in self-harm and suicidal ideation and education and training for GPs has been shown to be modestly effective in suicide prevention although not consistently.	Systematic Review J. John Mann, MD; Alan Apter, MD; Jose Bertolote, et al.	
112	SCM3	Training	Training of staff is associated with improved knowledge and confidence and also possibly improved patient outcomes (see De Beurs et al 2015. The Pitstop trial).	Many staff groups report a need for more training. Multiple training packages are available but the evidence base is uncertain. HEE/NCCMH have recently published training competencies for all staff.	https://www.hee.nhs.uk/our-work/mental-health/self-harm-suicide-prevention-frameworks
113	SCM4	Key area for quality improvement 1	Suicide prevention training for GP's and other gatekeepers who are likely to have contact with those at the greatest risk of suicide, such as nurses, police and prison officers	GPs are an important point of contact for those who are experiencing suicidal ideation. They receive no formal training and yet there is evidence that training GPs can help to reduce suicide.	
114	SCM6	Training by suicide prevention partnerships	Some evidence shows that training improves people's knowledge about suicide, the risks and how to prevent it. It may be an opportunity to reach people in non-traditional settings,	There are a huge range of different training packages available and it would be of benefit for there to be more guidance around quality, particularly as the HEE self-harm and suicide prevention competencies came out after the launch of the guidance.	Self-harm and suicide prevention frameworks https://www.hee.nhs.uk/our-work/mental-health/self-harm-suicide-prevention-frameworks
115	The Office of the Chief Allied Health Professions Officer- NHS England	Key area for quality improvement 3	NG105 1.7	Ensuring local availability and uptake of suicide prevention training, including primary care	
Additional areas – Managing transitions					
116	Body & Soul	Key area for quality improvement 3	There is ongoing concern of young people 'falling through the cracks' in their transition from CAMHS to adult	There is a lack of consensus on how these transitions should occur and at what age. Policies, frameworks and	Transition from CAMHS to Adult Mental Health Services (TRACK): A Study of Service Organisation,

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		Support during transitions in care	mental health services. Young people transitioning care are also undergoing developmental transition which leads to other challenges beyond (Royal College of Paediatrics and Child Health, 2003; Royal College of Nursing, 2004).	practices can differ greatly from child and adolescent service to adult mental health services, making the environment challenging to navigate.	Policies, Process and User and Carer Perspectives (singh et al, 2010) found here: http://www.netscc.ac.uk/hsdr/files/project/SDO_FR_08-1613-117_V01.pdf
117	INQUEST	Key area for quality improvement 5	Improved systems of support and planning around discharge, including to take account of increased needs for those With Autism Spectrum Disorder.		
118	NCD	**Specialist mental health care**	Based on the evidence of the national confidential inquiry, in particular the "10 ways to improve safety" that have come out of studies relating changes in service configuration to patient suicide rates in the UK. Standards would cover ward safety, early follow up on hospital discharge, specialist services working with substance misuse patients, etc.		https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(16)00063-8/fulltext
119	Smart rTMS Ltd	Transfer of care of patients assessed to be at risk of self-harm or suicide from the private sector mental health services to the NHS. This can occur when funding runs out or at the end of a course of treatment or due to patient preference or if	There are presently no national guidelines or standards for how this should be conducted. At present it is not possible in practice to transfer directly from private secondary mental health care services to NHS secondary health care services and referrals have to go via the GP. This can sometimes be affected by individual staff member's political views about private health care, which	I used to work for the Priory Group as a Consultant Psychiatrist for 8 years and now I am Medical Director of Smart rTMS a new national private repetitive Transcranial Magnetic Stimulation (rTMS) service. I have developed our own protocols and standards to meet the demands of this situation but the lack of recognition of this problem from the NHS perspective creates a continual risk which should be mitigated by the	There is presently no national data of which I am aware. Perhaps there should be.

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		the risk profile changes.	can result in discriminatory behaviour to the patient, which can increase the risk of self-harm or suicide. In high-risk cases the delay and communication lag while transfer to secondary NHS mental health services is organised may lead to an unacceptable risk. Sometimes the patient does not have a GP and in this situation they can be denied admission to a place of safety.	development of a shared protocol/standard	
Additional areas – NHS Health Checks					
120	Warrington Borough Council, Public Health Team on behalf of Local Suicide Prevention Partnership Board	Mental Health Assessment with NHS Health Check as a preventative measure	Current not mandated that mental health is part of physical health check. We know that men 40 – 59 are at greatest risk of suicide and these are the co-hort that will be called for a Health Check	The Health Check programme provides an opportunity to target males within the at risk age group to raise awareness around mental health, yet mental health is not currently mandatory within this check.	The rate of suicide is over three times higher for males (14.7 per 100,000) than it is for females (54.5 per 100,000). In Warrington, suicide rates are approximately 3 times higher in males than females, in keeping with national figures (ONS, 2017). This reinforces the need to ensure that suicide prevention work is directed more towards males.
Additional areas – People with coexisting mental illness and substance misuse					
121	NCD	**Specialist mental health care**	Based on the evidence of the national confidential inquiry, in particular the "10 ways to improve safety" that have come out of studies relating changes in service configuration to patient suicide rates in the UK. Standards would cover ward safety, early follow up on hospital discharge,		https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(16)00063-8/fulltext

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			specialist services working with substance misuse patients, etc.		
122	Warrington Borough Council, Public Health Team on behalf of Local Suicide Prevention Partnership Board	Cross work and referral between mental health and substance misuse services	We know that there is a strong correlation between substance misuse and suicide.	People unfortunately with substance misuse and mental health needs still get caught in between services. Need to be clear criteria between services.	Through years of research it is known that there are certain groups that are at a higher risk of dying by suicide. These groups include: • Young and middle-aged men; • People in the care of mental health services, including inpatients; • People with a history of self-harm, the risk being higher with increasing age at initial self-harm; • People in contact with the criminal justice system; • Alcohol or drug misuse (especially in men); • Specific population groups, such as doctors, nurses, veterinary workers, farmers and agricultural workers. . (HM Government, 2012, 2015 and 2017). In our local audit, a third of cases had a history of alcohol misuse (16 out of 49); the proportion was higher for females (58%; 7 out of 12) when compared to males (24%; 9 out of 37). A history of alcohol misuse was most prevalent in the age groups of under 24 and 45 to 64 years. Over a fifth of cases had a history of drug misuse (11 out of 49); the proportion was higher for females when compared to males. One in eight (12%) (6 out

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					of 49) had a history of both alcohol and drug misuse; all were female.
Additional areas – Trigeminal Neuralgia					
123	Trigeminal Neuralgia Association UK	Key area for quality improvement 1	There is a need for both the general public and medics to be aware of Trigeminal Neuralgia (TN) as it is often misdiagnosed.		
124	Trigeminal Neuralgia Association UK	Key area for quality improvement 2	As there is no test for diagnosing TN, it is essential that medics take the time to listen to the patient's pain history.		
125	Trigeminal Neuralgia Association UK	Key area for quality improvement 3	The delay between diagnosis, referral to a neurologist and then referral to a specialist is far too long and results in the patient experiencing excruciating pain before drugs are given to alleviate the symptoms		
Additional areas – Evaluation and research					
126	College of Mental Health Pharmacy (CMHP)	Embed research into all suicide prevention strategies so that tangible outcomes (including suicide rates) can be measured.	There is limited evidence on some of the public health interventions related to suicide prevention. It is essential that this is assessed to ensure the suspected benefit far outweighs any potential harm.	It is vital that we practice evidence based approaches. By documenting this, we can learn from our actions in years to come and other nations can learn from us.	The public health approach in the UK is very much focused on open conversations re suicide, we intuitively feel is the right thing. Prof Stan Kutcher had done much work in this area in Canada and highlighted that there is a need for more evidence-gathering regarding community-based interventions. He proposes gate-keeper training as an effective intervention for a reduction in suicide rates and sites the Army and the Airforce, where reduction in suicide rates has been

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					attributed to gate-keeper training. Ref Kutcher S. Suicide risk management. London: BMJ Best Practice, 2018. https://bestpractice.bmj.com/topics/en-gb/1016
Additional areas – National legal and performance framework					
127	Festival of Life and Death	Key area for quality improvement 2 Establish ZERO SUICIDE aim for UK (subject to suitable nuanced equivalent language depending on audience.)	It is not possible to achieve anything significant without a bold clear aim. Moreover we are trying to transform. Transformation requires much bigger bolder leadership than currently happens.	This is an accepted principle of transformational leadership – to have a clear bold aim. N.B. There is a difference between a corporate/national aim, and individual job accountabilities. This is about a national aim, not individual job accountabilities, as in performamnce appraisals.	The default /historical 10% reductions targets equate to a target of maintaining and being satisfied by 90% suicide levels. We can expect 10% reduction anyway with declining debt levels since the worst of the financial crash. It is simply unacceptable to have a target that is anything more than zero.
128	Festival of Life and Death	Key area for quality improvement 5 Embed suicide prevention into corporate and political governance, corporate regulation. Take legal action against directors of corporations and institutions whose actions contribute to suicide attempts and suicides.	Most of the corporate and institutional sector will not change unless caused to to do so by law. This is particularly so of the most pressurised and competitive industries. Industries such as food, drink, tobacco, finance, gambling knowingly design and market products/services to people – especially vulnerable people – that are harmful, via addiction,	Evidence is everywhere that corporations help to kill people. We accept without question that a corporation that harms or kills someone via tangible physical safety negligence is criminally liable. The same should apply for negligence or intent to exploit people in ways that are harmful to health. This should extend to customers and staff, and anyone affected, just like the liabilities for discrimination, etc.	This is obvious, but authorities, regulatory agencies and politicians dare not suggest it because they are frightened of upsetting big business. This is the same regulatory inertia that sustained the slave trade, homosexual criminalisation, tobacco, and now sustains ill-health caused by corporate recklessness.

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			stress, lifestyle, diet/obesity, etc.		
General					
129	HM Prison and Probation Service			The keys areas highlighted above are all issues arising from investigations into self-inflicted deaths in custody (occurring in in Prisons and Probation Ombudsman's recommendations and Coroner's Prevention of Future Death reports).	
130	Royal College of Paediatrics and Child Health	Key area for quality improvement 1			The reviewer was happy with the topic overview and had no improvements to make
131	SCM5	Additional developmental areas of emergent practice			There is some information around applying evidence based zero suicide prevention models here
132	Warrington Borough Council, Public Health Team on behalf of Local Suicide Prevention Partnership Board	Suicide Prevention			Warrington Local Suicide Audit Report can be found at https://www.warrington.gov.uk/download/downloads/id/16558/warrington-suicide-audit-2018.pdf