

<b>Report to:</b>	<b>EXECUTIVE CABINET</b>
<b>Date:</b>	24 April 2019
<b>Executive Member/Reporting Officer:</b>	Councillor Brenda Warrington – Executive Leader Pat McKelvey, Head of Mental Health and Learning Disabilities and Jacqui Dorman, Public Health Intelligence Manager
<b>Subject:</b>	<b>SUICIDE PREVENTION STRATEGY 2019/2023</b>
<b>Report Summary:</b>	<p>The number of deaths to suicide in Tameside and Glossop is significant, with 75 deaths occurring in 2015/17 alone. This strategy builds on our work to date and sets out an ambitious five year plan for reducing and ultimately eliminating suicides in Tameside and Glossop. To do this will require a co-ordinated effort so that suicide prevention becomes ‘everyone’s business’.</p> <p>Our vision is that no-one will see suicide as a solution, and our ambition is therefore that there will be no more suicides in Tameside and Glossop.</p> <p>This strategy sets out how we will go about preventing suicide in Tameside and Glossop, in line with our ambition. In order for this to be achieved, all partners in every organisation in Tameside and Glossop will need to understand and support this strategy.</p>
<b>Recommendations:</b>	To approve the suicide prevention strategy and its ambition and objectives
<b>Financial Implications: (authorised by Section 151 Officer)</b>	<p>On 30 January 2018 the Strategic Commissioning Board approved an investment programme in Mental Health services by an additional recurrent value of £ 5.791 million by 2021/22, £ 5.691 million of which is within the Section 75 of the Integrated Commissioning Fund, with £ 0.100 million within the aligned fund. The aligned fund investment was approved at the CCG Governing Body on 28 March 2018.</p> <p>Whilst this report is not specifically requesting any further additional funding, it should be acknowledged that there is a clear investment plan which sets out the level of funding available for each programme of work. The investment programme included funding to support the prevention strategy as explained in this report.</p>
<b>Legal Implications: (authorised by Borough Solicitor)</b>	It is important to ensure that individual cases and the outcome of inquest, which are an inevitable consequence, are taken into account when devising this type of strategy. The Coroner will require sight of and may require details of the governance and rationale behind the strategy, the policy and any procedures and processes which flow from this decision when considering this category of death. They therefore must be kept under regular review and linked to all agencies involved with inquests.
<b>Corporate Plan:</b>	The suicide prevention strategy sets out the strategic direction to reduce suicides in Tameside and Glossop. It directly aligns with our priority to increase healthy life expectancy and reduce inequalities.

**Policy implications:**

The suicide prevention strategy sets out the strategic direction to reduce suicides in Tameside and Glossop. It aligns with the direction being taken by the GM Health & Social Care partnership and the locality plan which aims to increase healthy life expectancy and reduce inequalities

**Risk Management:**

This report fulfils the commitment for the delivery of a suicide prevention strategy as part of our public health statutory duties and aligns with the ambition for Greater Manchester to substantially reduce deaths from suicide

**Access to Information :**

The background papers relating to this report can be inspected by contacting Jacqui Dorman, Policy, performance and intelligence



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# **Tameside & Glossop Suicide Prevention Strategy 2019-2023**



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Report of	Suicide and self-harm prevention group
On behalf of	Health and Wellbeing Board, Strategic Commissioning Board and the Mental Health and Wellbeing Strategic Group
Contributors	Pat McKelvey
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## 1. FORWARD

- 1.1 In England, one person dies every two hours as a result of suicide. When someone takes their own life, the effect on their family and friends is devastating. Many others involved in providing support and care will feel the impact. Suicide is often the end point of a complex history of risk factors and distressing events; the prevention of suicide has to address this complexity.
- 1.2 There are marked differences in suicide rates according to social and economic circumstances, so suicide is also a marker of how fair our society is. Those who are out of work, in poor housing, and/or with a significant health issue, (particularly those who are dependent upon drugs and alcohol) are more at risk. Reducing risk requires system change to address the wider determinants of mental health in addition to high quality health and social care in its widest sense. This presents us with a considerable challenge at a time when resources are more stretched than ever.
- 1.3 It is clear that nationally and locally our collective goal is that ***no-one will see taking their own life as a solution***, and to this end our commitment in Tameside and Glossop is that we will do everything in our power to achieve this.
- 1.4 In developing our strategy we have taken inspiration from the Greater Manchester Suicide prevention strategy<sup>1</sup> and thus we take the opportunity here to acknowledge the excellent work of all our all colleagues working on this agenda across the region.

## 2. EXECUTIVE SUMMARY

- 2.1 The number of deaths to suicide in Tameside and Glossop is significant, with 75 deaths occurring in 2015/17 alone. The majority of suicides occur in men, with increased risk seen in those within the lowest socioeconomic groups and living in the most deprived geographical areas. Other at risk groups includes those who self-harm, children and young people and those with untreated depression. Individuals who have been bereaved by suicide, those who are isolated, and those who misuse drugs and alcohol are also at increased risk.
- 2.2 Less than a third of all suicides occur in individuals who are known to mental health services, thus preventing suicide requires a co-ordinated whole system approach.
- 2.3 This strategy builds on our work to date and sets out an ambitious five year plan for reducing and ultimately eliminating suicides in Tameside and Glossop. To do this will require a co-ordinated effort so that suicide prevention becomes 'everyone's business'.
- 2.4 We have sought direction from the Suicide Prevention Strategy for England<sup>2</sup> from 2012, the Five Year Forward View for Mental Health<sup>3</sup>, and the recently published PHE resources for local Suicide Prevention Planning<sup>4</sup>.

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<sup>1</sup> <https://www.gmhsc.org.uk/wp-content/uploads/2018/05/GM-Suicide-Prevention-24.02.17.pdf>

<sup>2</sup> <file:///N:/Transformation/MH%20&%20LD/Suicide/GM/Preventing-Suicide-England.pdf>

<sup>3</sup> <https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf>

2.5 In Tameside & Glossop we are aiming for Suicide Safer Communities Accreditation and have therefore based our strategy objectives in line with the 'Nine Pillars of Suicide Prevention'. These are:

1. A leadership/steering committee
2. A robust background summary of the local area to support goal setting
3. Suicide Prevention Awareness raising
4. Mental Health and Wellness promotion
5. Training for community members, lay persons and professionals
6. Suicide intervention and ongoing clinical support services.
7. Suicide bereavement support and resources
8. Evaluation measures including data collection and evaluation system
9. Capacity building/sustainability within communities

### **3. WHAT WE WANT TO ACHIEVE IN TAMESIDE AND GLOSSOP?**

- 3.1 Our vision is that no-one will see suicide as a solution, and our ambition is therefore that there will be no more suicides in Tameside and Glossop.
- 3.2 We recognise that from the evidence that suicides are mainly preventable and avoidable. With this in mind, our strategy sets out our plan to ensure that we harness the support and contribution of all services and agencies so that we can reduce risk, proactively intervene when needed, and effectively respond to those in crisis.
- 3.3 Our primary focus for the first two years of our strategy (2018/19 – 2019/20) will be to meet the challenge set out within the Five Year Forward View for Mental Health i.e. to reduce the rate of suicide by 10% by 2020. Thereafter we will seek to stretch this target further.

### **4. WHAT IS THE PURPOSE OF THIS STRATEGY?**

- 4.1 This strategy sets out how we will go about preventing suicide in Tameside and Glossop, in line with our ambition that there will ultimately be no more suicides. In order for this to be achieved, all partners in every organisation in Tameside and Glossop will need to understand and support this strategy.
- 4.2 Our strategy is intended to stimulate a social movement for change in the way we think and act in relation to suicides and suicide prevention. We aim to enhance the skills of our wider workforce in relation to assessing and managing risks and supporting those who are affected or bereaved, to reduce the stigma attached to talking about suicide and mental health more openly, and to promote suicide safer communities.
- 4.3 As previously stated this strategy is based primarily on the Greater Manchester suicide strategy but with a focus on the outcomes and priorities for Tameside and Glossop. It will

also link with the priorities and strategic framework developed for Derbyshire 2018/21, as the Glossop resident population fall under the responsibility of Derbyshire County council within the local authority area of High Peak<sup>5</sup>. However from a registered population perspective, patients registered with a Glossop GP are the responsibility of the Tameside & Glossop Strategic Commission and therefore this strategy encompasses the Tameside resident population and the Tameside & Glossop registered population.

## 5. WHY WE NEED A SUICIDE PREVENTION STRATEGY?

### 5.1 *Key drivers*

- 5.1.1 Suicide is a major mental health, social, economic, and public health issue.<sup>6</sup> It is a major cause of early death and an indicator of underlying poor mental health at a population level and represents a devastating loss for individuals, families and communities and carries a huge financial burden.<sup>7</sup> The highest numbers of suicides are found in men aged 45–54 years, and in women aged under 45 years.
- 5.1.2 By 2020/2021 our local health and social care system faces an estimated financial deficit of £42 million to £180 million<sup>8</sup> indicating the need for radical transformation. The impacts of mental health on our wider health care system are considerable: we know that poor mental health worsens physical illness and raises total health care costs by at least 45%, for example, an estimated 12% - 18% of all NHS expenditure on long term conditions is linked to poor mental health and wellbeing.
- 5.1.3 Most importantly, this strategy recognises that suicide has a significant toll on others – i.e. estimates suggest that for every person who dies from suicide at least 10 people are directly affected.<sup>9</sup> Also for each case of suicide we know that there are around nine others that will have attempted suicide. Thus each suicide is an indication of a significant number of individuals who need help and support.
- 5.1.4 The key national driver for the development of local suicide prevention strategies and action plans was set out within the 2012 strategy for England Preventing Suicide in England, a cross government strategy to save lives<sup>10</sup>. The requirement for a comprehensive local suicide strategy is considered to be an effective mechanism in reducing deaths by suicide by supporting the combination of a range of interventions.
- 5.1.5 More latterly, the Five year forward view for Mental Health<sup>11</sup> set a requirement for all local areas to have Suicide Prevention plans in place by 2017.

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<sup>5</sup> [Derbyshire self-harm and suicide prevention framework 2018/21](#)

<sup>6</sup> <https://www.mentalhealth.org.uk/a-to-z/s/suicide>

<sup>7</sup> Pitman AL, Osborn DPJ, Rantell K, King MB. 2016 Bereavement by suicide as a risk factor for suicide attempt: a cross-sectional national UK-wide study of 3432 young bereaved adults. *BMJ Open* 2016 Jan 1;6(1)

<sup>8</sup> Greater Manchester Suicide prevention strategy 2016

<sup>9</sup> <https://www.mentalhealth.org.uk/a-to-z/s/suicide>

<sup>10</sup> Preventing Suicide in England: A cross government strategy to save lives (2012)

<https://www.gov.uk/government/publications/suicide-prevention-strategy-for-england>

<sup>11</sup> The five year forward view for mental health (2016)

5.1.6 A Tameside and Glossop approach that follows the Greater Manchester approach also presents an opportunity to achieve parity of access for all our residents, through a combination of a framework for action to which all boroughs can pledge their support and the potential for economies of scale when commissioning interventions for Tameside and Glossop with the whole of Greater Manchester. It will also allow us to promote the prevention of suicide as everyone's business; with key stakeholders (including the media) joining forces to support workers and residents to reduce the stigma surrounding suicide, and to take action.

5.2 Outcomes we want to achieve in Tameside and Glossop Suicide Prevention.

5.2.1 Our strategy supports us in focusing on all six areas of the national strategy in the long-term, however the outcomes we want to achieve for the whole system in the short term are<sup>12</sup>:

1. Reducing the risk in Men
2. Preventing and responding to self-harm
3. Improving outcomes for children and young people and women during pregnancy and postnatally
4. Treating Depression more effectively in Primary Care
5. Improving Acute Mental Health Care Settings
6. Tackling High Frequency Locations
7. Reducing Isolation and Loneliness
8. Improving Bereavement Support /Postvention

## **6. THE NATIONAL, REGIONAL AND LOCAL PICTURE**

6.1 National

6.1.1 The recent publication of the 2016 National Confidential Inquiry into Suicide and Homicide by People with Mental Illness<sup>7</sup> (NCISH) shows that suicide is the biggest killer of men under 49 years and it remains the leading cause of death in people aged 15-29<sup>13</sup>. The majority of people (two thirds) who die by suicide are not in contact with mental health services<sup>14</sup> and in England one person dies as a result of suicide every 2 hours.<sup>15</sup>

6.1.2 For every one person who dies from suicide, at least 10 others are directly affected. In 2017, there were 4,451 deaths from suicide in England, of which 224 were in Greater Manchester and 19 were in Tameside. From 2004 to 2017 there was a 26% fall in suicide rates in men aged 30 to 34. However since 2006, suicide rates in men aged 45-59 have risen by 11%. We also know that specific groups appear to be at higher risk. The following risk factors have become more common as antecedents to suicide.<sup>16</sup>

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<sup>12</sup> Appleby, L (2016) 'Priorities for Suicide Prevention action plans' in Local Suicide Prevention Planning – A Practical Resource. Public Health England.

<sup>13</sup> Office of National Statistics, What do we die from? (2015)

<sup>14</sup> HM Government Preventing suicide in England A cross-government outcomes strategy to save lives (2012)

<sup>15</sup> Self-harm, suicide and risk: helping people who self-harm (2010) Royal College of Psychiatrists

<sup>16</sup> Appleby L et al (2016) National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. The University of Manchester. Commissioned by the Healthcare Quality Improvement Partnership (HQIP)



- Isolation
- Economic adversity
- Alcohol and drug misuse
- Recent self-harm

6.1.3 People in the most deprived areas are ten times more at risk of suicide than those in the most affluent group living in the most affluent area. The strongest predictor of suicide is previous episodes of self-harm with the most common antecedent to suicide being alcohol use.

6.1.4 Nationally the most common methods of suicide are hanging and strangulation (47%), self-poisoning (overdose) (21%) and jumping and multiple injuries (mainly jumping from a height or being struck by a train) (11%). Less frequent methods are drowning (4%), gas inhalation (including carbon monoxide poisoning (3%), cutting and stabbing (3%) and firearms (2%).

6.1.5 Suicides amongst those who are under the care of mental health services appears to be decreasing overall, although this picture is not uniform – with inpatient suicides falling significantly (by 60%) following the decree by government in 2003 to eliminate ligature points on inpatient mental health wards, although there are still in excess of 75 inpatient deaths each year.

6.1.6 An increase in suicides under the care of crisis teams is clear from the data which is considered to be as a result of pressure on the system i.e. as a consequence of community crisis teams taking on more complex clients as a result of scarcity of inpatient beds.<sup>17</sup>

6.1.7 The NCISH report indicates that effective crisis teams can have an essential role in reducing suicides - a third of suicides amongst those under the care of mental health services have been discharged from hospital within the preceding 7 days. 30% of suicides in this group occur in the space between discharge and the first outpatient appointment at 7 days plus, reducing this gap to 2-3 days can reduce this to 11%<sup>18</sup>.

## 6.2 Greater Manchester

6.2.1 The total population of Greater Manchester is approximately 2.8 million people. In 2017 there were 224<sup>19</sup> deaths by suicide in Greater Manchester. The greatest number (31) were seen in Bolton and Salford, with the lowest in Trafford (N=15) (table 1)

<sup>17</sup> Greater Manchester suicide audit 2017

<sup>18</sup> Appleby L et al (2016) National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. The University of Manchester. Commissioned by the Healthcare Quality Improvement Partnership (HQIP)

<sup>19</sup> ONS:

[www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/suicidesbylocalauthority](http://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/suicidesbylocalauthority)

Table 1 Numbers of suicides by Borough (2017)

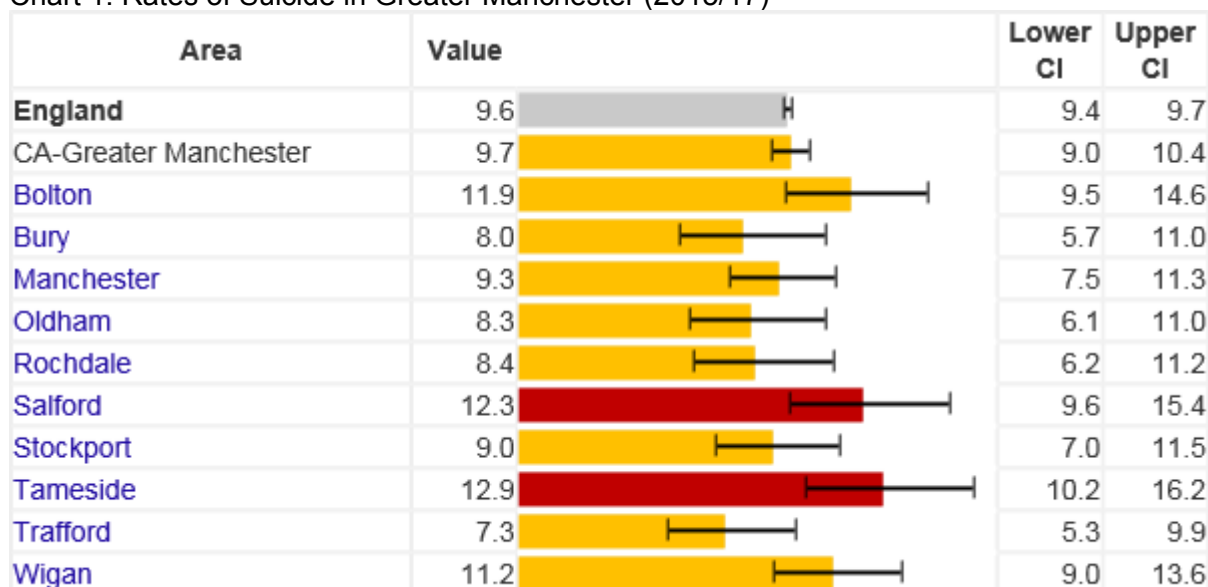
Local Authority	Number of Suicides
Bolton	31
Bury	13
Manchester	30
Oldham	18
Rochdale	18
Salford	31
Stockport	19
Tameside	19
Trafford	15
Wigan	30
<b>Greater Manchester</b>	<b>224</b>

### 6.3 Tameside and Glossop

- 6.3.1 As the Locality of Tameside and Glossop covers two local authority areas and as previously stated this Strategy covers both Tameside and Glossop, however as the public health responsibility for suicide prevention sits with the local authorities the majority of the publicly available statistics reported in this strategy are at a Tameside level only. Further work will take place with Derbyshire County Council to ensure the whole system approach is embraced equally in Glossop as in Tameside. As also previously mentioned, this strategy will link closely with the priorities for suicide prevention for Derbyshire using their Suicide prevention framework 2018/21 as a reference in the development of our suicide prevention action plans.<sup>20</sup>
- 6.3.2 Of the 4,451 deaths registered in 2017 for suicide in England, suicides in Greater Manchester constituted around 5% (n=224) of these, reflecting the significant regional and national burden of suicide within the population.
- 6.3.3 In 2017 there were 19 deaths registered for suicide in Tameside, this is nineteen too many and places Tameside 5th highest across Greater Manchester for numbers of suicides in 2017. Between 2015/17 there were 5 suicides across Glossop.
- 6.3.4 Of the 224 deaths from suicide in Greater Manchester in 2017, suicides in Tameside constituted around 8% of these, reflecting the significant local burden of suicide within our population.

<sup>20</sup> Derbyshire self-harm and suicide prevention framework 2018/21

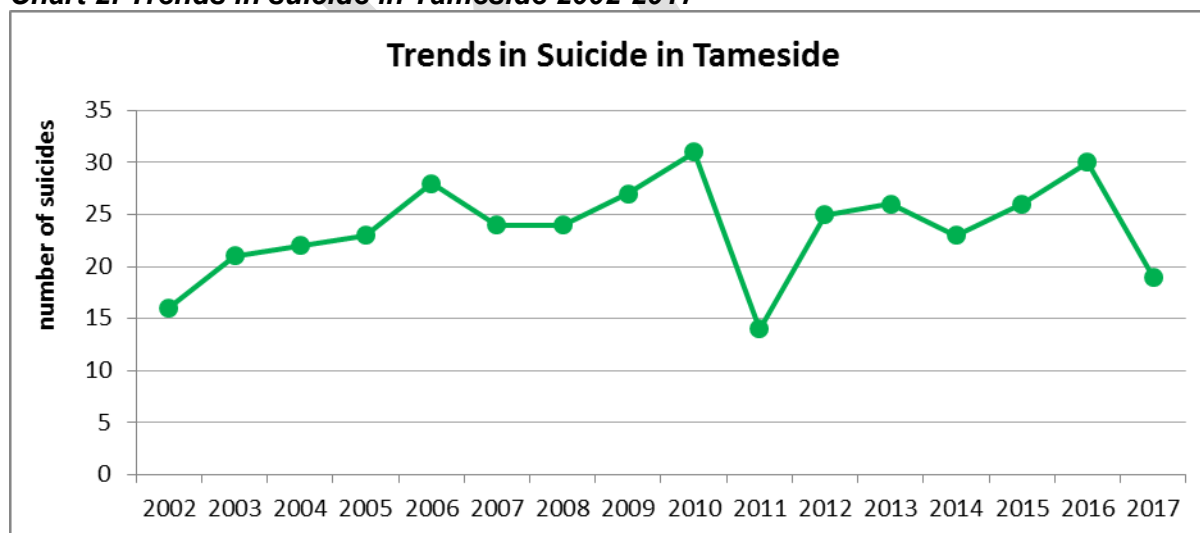
Chart 1: Rates of Suicide in Greater Manchester (2015/17)



Source: Public Health England (based on ONS source data)

6.3.5 Rates of suicide in Tameside have fluctuated somewhat but overall have been on the rise since 2002, peaking in 2010, but rising again from 2011. (Chart 2) The overall rate of suicide in Tameside between 2015/17 was 12.9 (per 100,000 residents),<sup>21</sup> (chart 1) making this the highest rate in Greater Manchester over the 3 year period, with significant variation between wards and different population groups.

Chart 2: Trends in suicide in Tameside 2002-2017



Source ONS

## 7. KEY RISKS FACTORS TO SUICIDE

7.1 Understanding the key risks in relation to suicide enables targeted approaches to those most in need of intervention. A local suicide audit suggested that Tameside fits the national and regional picture with regard to overarching demographic, social and economic factors which place residents at higher risk of suicide.

<sup>21</sup> Suicide prevention profiles\_ PHE\_ 2014/16

7.2 Men are five times more likely to die by suicide than women in Tameside,<sup>22</sup> three times higher on average in England<sup>23</sup> and people in the lowest socio-economic group and living in deprived areas appear to be more at risk of suicide than those in the most affluent groups living in the most affluent areas.<sup>24</sup>

7.3 Local evidence suggests that those most at risk are:

- Men
- People with prior mental health issue such as depression and anxiety
- Relationship breakdown
- Loss of job
- Chronic pain or disability
- People with longstanding issues with drugs and or alcohol
- People with financial issues/debt

These are similar to what the national evidence suggests that those most at risk nationally are:

- Men
- Individuals aged 35-49
- People with a recent history of self-harm
- People in the care of mental health services
- People in contact with the criminal justice system
- Specific occupational groups, such as doctors, nurses, veterinary workers, farmers and agricultural workers<sup>25</sup> and veterans.

7.4 The incidence of self-harm as a precursor to suicide has seen a steep rise, calling for better assessment of those presenting to services. In 2016/17 there were 512 hospital admissions due to self-harm in Tameside.<sup>26</sup> Of these, evidence suggests that patients can often present with a complex history of risk factors and events leading up to admission including:

- Untreated depression
- Unemployment
- Debt
- Relationship breakdown and bereavement including by suicide
- Drug and alcohol misuse
- Social isolation<sup>27</sup>

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<sup>22</sup> A suicide audit for Tameside 2013-2016

<sup>23</sup> <http://web.ons.gov.uk/ons/rel/subnational-health4/suicides-in-the-united-kingdom/2014-registrations/>

<sup>24</sup> Platt, S. Inequalities and suicidal behaviour; In O'Connor, R.C. et al. International handbook of suicide prevention: research, policy and practice. 2011

<sup>25</sup> Op.cit. HM Government (2012)

<sup>26</sup> <https://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide/data#page/4/gid/1938132834/pat/126/par/E47000001/ati/102/are/E08000008/iid/21001/age/1/sex/4>

<sup>27</sup> PHE Local suicide prevention planning A practice resource (2016)

7.5 Key risk factors for the under 25s are:<sup>28</sup>

- Family factors such as mental illness
- Abuse and neglect, Bereavement and experience of suicide
- Bullying, Suicide-related internet use
- Academic pressures, especially related to exams
- Social isolation or withdrawal
- Physical health conditions that may have social impact
- Mental ill-health, self-harm and suicidal ideas

7.6 In contrast, certain protective factors are evident from the data on suicides, which include:

- Effective coping and problem solving skills
- Presence of reasons for living, hopefulness and optimism
- Physical activity and health
- Family connectedness
- Supportive schools and Social support
- Religious participation, Employment
- Lack of exposure to suicidal behaviour
- Traditional social values
- Access to health treatment<sup>29</sup>

7.7 It is reasonable to assume therefore that strategies which seek to increase these protective factors at a population level are likely to be of benefit in reducing overall risk.

## 8. STRATEGIC APPROACH

### 8.1 National Strategy

8.1.1 The Five Year forward view for Mental Health (2016) sets out the challenge to reduce suicides by 10%, and several strategies around the UK have clearly stated their intent to go much further than this – toward a zero suicide approach. This too is our ambition. We intend to adopt a focused approach to achieving this goal by targeting those deaths which are most preventable by identifying specific at-risk groups, communities or settings for action. We will use the intelligence gathered via the GM and local Suicide Audits to inform where our efforts might be best targeted in addition to national priority groups. This strategy acknowledges and builds on a substantial body of work in relation to suicide prevention in Greater Manchester and reflects the learning of a programme of sector led improvement undertaken in 2013. Our overarching objectives are aligned with the six national priorities (2012) and national refresh (2017).

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<sup>28</sup> National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) Suicide in children and young people. (2016)

<sup>29</sup> Scottish Government Social Research Risk and Protective Factors for Suicide and Suicidal Behaviour: A Literature Review (2008)

8.1.2 The strategic priorities nationally are set out below and this strategy principally focuses on actions that support those objectives which can be delivered or supported by utilising a Greater Manchester and local approach.

## 8.2 National Priorities for Action

8.2.1 The National Suicide Prevention strategy of 2012 set out six priority areas for action:<sup>30</sup>

1. Reduce the risks in key-high risk groups
2. Tailor approaches to improve mental health in specific groups
3. Reduce access to means of suicide
4. Provide better information and support to those bereaved or affected by suicide
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour
6. Support research, data collection and monitoring

8.2.2 These six areas for action have been used as a framework for this Strategy, and to develop our overarching aims and objectives and supporting action plan.

8.2.3 The more recent national strategy refresh (January 9th 2017) stays true to these themes with an additional emphasis on

- Better and more consistent local planning and action by ensuring that every local area has a multi-agency suicide prevention plan by 2017, with agreed priorities and actions.
- Better targeting of suicide prevention and help seeking in high risk groups such as middle-aged men, those in places of custody/detention or in contact with the criminal justice system and with mental health services
- Improving data at national and local level and how this data is used to help take action and target efforts more accurately
- Improving responses to suicide
- Expanding the scope of the national strategy to include self-harm prevention in its own right.

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<sup>30</sup> <https://www.gov.uk/government/publications/suicide-prevention-strategy-for-england>

## 9. TAMESIDE & GLOSSOP MENTAL HEALTH APPROACH

### 9.1 The overarching Tameside & Glossop Mental Health Approach

9.1.1 This suicide prevention strategy forms part of an overarching approach for mental health in Greater Manchester and in Tameside and Glossop. This broader strategy for GM is summarised in **Appendix 2**, and sets out the vision to improve child and adult mental health, narrow the gap in life expectancy and ensure parity of esteem with physical health. The vision also commits to shifting the focus of care toward prevention, early intervention and resilience and toward delivering a sustainable mental health system. Simplified and strengthened leadership and accountability is at its core, as is the enablement of resilient communities, the engagement of inclusive employers and close partnership working with the third sector.

9.1.2 To achieve these goals in Tameside and Glossop we intend to strengthen our mental health system, and this will be achieved through four key characteristics which run throughout our plans:

- Prevention
- Access
- Integration
- Sustainability

9.1.3 A number of 'golden threads' also run throughout our strategy, including

- Parity of Esteem
- Research deployed to inform best practice
- Using technology to provide new and innovative forms of support
- Leverage the learning from successful programmes (e.g. Troubled families)
- Workforce Development,

This Suicide Prevention strategy stays true to these principles

9.2 As one of four national sites chosen by the Innovation Unit our local Living Life Well Programme, supported by the Big Lottery Fund, will design a new model of care that ensures that people with mental health conditions will

- Have no gap between services
- Have no wrong door and no silo working
- Get swift and easy access to life changing support and interventions
- Get help in a crisis and get the right support required
- Have access to early support to prevent crises from happening
- Have less need for in-patient care
- Have access to alternatives to hospital admission

9.3 Starting with the 101 Days for Mental Health Project in summer 2018 we have co-produced a new model of care in the neighbourhoods that meets the currently unmet mental health care needs of individuals in Tameside and Glossop. We are expanding the principles of this model into our work on mental health crisis care.

- 9.4 All of this new development is supported by the Strategic Commissioning Board's commitment to improving the mental health of the Tameside and Glossop population by agreeing to prioritise increasing investment to improve parity of esteem.
- 9.5 The Board has agreed to a plan to invest £6million recurrently from 2018 until 2021 on a phased basis in order to support the following objectives:-
- Affordability;
  - Development of robust business cases for each scheme;
  - Phased approach to building complex services;
  - Recognition of the time lag in recruitment to mental health posts.
- 9.6 The investment is focussed on:
- Increasing opportunities for people to stay well in the community
  - Increasing opportunities to get help before/during a crisis
  - Making effective use of secondary care

## 10. SUICIDE PREVENTION OUTCOMES WE WANT TO ACHIEVE

- 10.1 Our key priority areas for actions and outcomes for preventing suicide in Tameside and Glossop are described in the recent Public Health England resource for suicide prevention<sup>31</sup>. Following the completion of the Tameside and Glossop suicide audit this will be enhanced to reflect the findings. It is also important to note that this suicide prevention strategy cannot operate in isolation. As stated previously, suicide is complex and intrinsically linked to deprivation, unemployment, debt, substance misuse, social isolation and other adverse experiences people in Tameside and Glossop live with. Therefore this strategy needs to work alongside the corporate plan, (**Appendix 3**), the local poverty strategy and the health and wellbeing strategy.



### *1. Reducing the risk in men*

We will reduce risk in men, in particular middle aged men, we will do this by focusing on economic disadvantage such as debt and or unemployment, social isolation and drugs and alcohol misuse. A focus on developing treatment and/or support settings that are more acceptable and accessible by men

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<sup>31</sup> Appleby, L (2016) 'Priorities for Suicide Prevention action plans' in Local Suicide Prevention Planning – A Practical Resource. Public Health England







## **7. Tackling high frequency locations**

This includes making high risk public areas safer and working with the local media organisations and groups to prevent imitative suicides



## **8. Bereavement Support and Media engagement**

We will ensure there is better provision of information and support for those bereaved or affected by suicide and support the media in delivering sensitive *approaches to suicide and suicidal behaviour*

## **11. OUR OBJECTIVES**

- 11.1 The action plan for 2019/20 to support the delivery of this strategy can be found in **Appendix 1**. The action plan will be the parameter by how we ensure the implementation of our objectives to achieve the outcomes we aspire to. The measure of success of both the strategy and action plan will be a substantive reduction in suicide in Tameside & Glossop over the course of the strategy. Below is a summary of our strategic objectives and associated 'pledges' that this strategy makes for 2019-2023.

### **Strategic Objectives**

- 11.2 Our strategic objectives are described against the Suicide Safer Communities Accreditation '*Nine Pillars of Suicide Prevention*'. These are

1. A leadership/steering committee
2. A robust background summary of the local area to support goal setting
3. Suicide Prevention Awareness raising
4. Mental Health and Wellness promotion
5. Training for community members, lay persons and professionals
6. Suicide intervention and ongoing clinical support services.
7. Suicide bereavement support and resources
8. Evaluation measures including data collection and evaluation system
9. Capacity building/sustainability within communities

### **11.3 Pillar 1: A leadership/steering committee**

- (a) Securing high level political support for suicide prevention, with support from local political mental health champions within Tameside and Glossop
- (b) We will establish an executive chair and review the Terms of Reference for the Tameside & Glossop Suicide and Self Harm Prevention Group
- (c) The Group is responsible for developing and delivering this Strategy and be held to account by the Tameside and Glossop Mental Health Strategy Steering Group. The

Group will also provide an annual update to the Tameside Health and Well-being Board

- (d) Membership of the group will include people with lived experience, voluntary sector groups, health providers, blue light services and commissioners.

#### **11.4 Pillar 2: A robust background summary of the local area to support goal setting**

- (a) This Strategy is based on the Tameside audit of suicides registered between 2013 and 2017
- (b) We will redo the audit every 5 years and share learning across Greater Manchester and support the production of a GM annual audit
- (c) We will use the audit process to identify high risk locations and or new and emerging means of suicide and put in place plans to reduce related risks.
- (d) We will support and attend the annual suicide prevention conference for Greater Manchester to share learning, good practice and strengthen links between agencies

#### **11.5 Pillar 3: Suicide Prevention Awareness raising**

- (a) We will work to develop and deliver the Greater Manchester Suicide Prevention Campaign 2019 and deliver a local boost to the campaign
- (b) In partnership with Greater Manchester and Public Health England, we will look at the potential for a social marketing initiative that will stimulate a social movement for change with regard to eliminating the stigma associated with suicide and self-harm.
- (c) We will review the learning from other localities and work with local residents to design a campaign to target men in particular
- (d) We will work with colleagues in the media to agree standards of reporting of suicide and maximise opportunities to signpost and raise awareness
- (e) We will work together to develop a World Suicide Prevention Day
- (f) Being open, receptive and supportive of social movements that improve public awareness of suicide prevention through campaigns or social media platforms

#### **11.6 Pillar 4: Mental Health and Wellness promotion**

- (a) We will embrace Public Health England's new 3-year mental health campaign in 2019.
- (b) Working with colleagues in schools to raise awareness of emotional wellbeing amongst young people
- (c) Working with the GM Parent Infant Mental Health Programme to promote mental well-being of parents in pregnancy and beyond
- (d) Promoting mental health in our workplaces and amongst our staff, especially those in higher risk occupations, and promote approaches that reduce stigma
- (e) We will work with local faith group leaders to share knowledge and understanding of suicide in relation to culture and faith.

#### **11.7 Pillar 5: Training for community members, lay persons and professionals**

- (a) We will develop a Training Ladder and establish a rolling programme of training at all levels, monitoring the uptake each year

- (b) We will support staff groups who wish to develop their knowledge skills and confidence such as primary care practitioners and pharmacies, and in management of risks in primary care
- (c) We will work with primary care professionals such as GPs and practice nurses to better understand risk by utilising models such as the five Ps psychological assessment tool.<sup>32</sup>
- (d) Working with the community and voluntary sector by supporting collaboration such as a voluntary sector Health and Wellbeing Alliance in Tameside and Glossop

#### 11.8 **Pillar 6: Suicide intervention and ongoing clinical support services**

- (a) We will ask Pennine Care to demonstrate its work toward the elimination of suicides in in-patient and community mental health care services through reporting on a bi-annual audit of quality improvement in Tameside and Glossop services in relation to the 10 ways to improve patient safety, listed below.<sup>33</sup>
  - Safer wards (e.g. prescribing, eliminating ligature points)
  - Early follow up on discharge (within 2-3 days)
  - No out of area admissions
  - 24 hour crisis teams (sign up to the crisis care concordat)
  - Family involvement in 'learning lessons'
  - Guidance on depression
  - Personalised risk management
  - Outreach teams
  - Low staff turnover
  - Dual Diagnosis support (i.e. Alcohol and Drugs)
- (b) Our neighbourhood mental health Minds Matter service will offer swift and easy access to people wanting support and advice regarding their mental health across all five neighbourhoods
- (c) We will develop a STORM pathway within our Minds Matter service; ensuring people identified with high risk of suicide are offered comprehensive support
- (d) We will improve crisis services including establishing a mental health observation and assessment room and increasing the capacity of the Home Treatment Team support people at home in place of a hospital admission
- (e) Review the management of depression in primary care and scope the potential for a minimum/optimal standard for risk assessment tools in primary care
- (f) We will establish an All-Age RAID service at Tameside Hospital, including a service for vulnerable children and young people, working in partnership with the GM CYP Crisis developments
- (g) We will review of Parent Infant Mental Health Pathway following the roll out of the new GM Perinatal Community Mental Health team in order to strengthen further comprehensive support to both parents in pregnancy and the two years following birth.
- (h) We will finalise our review of Psychological Therapies with the goal of continuing to improve access to and waiting times for psychological therapy. This includes IAPT for long term conditions.

<sup>32</sup> <https://www.psychologytools.com/worksheet/friendly-formulation/>

<sup>33</sup> Appleby, L et al (2016) Making Mental Health Care Safer: Key findings from the National Confidential Inquiry into Suicides and Homicides. Manchester University.

- (i) We will review local self-harm care pathways against NICE guidance (CG133) and complete a self-harm audit to enable us to better understand the reasons behind self-harm and to assess outcomes against evidenced standards.
- (j) We will establish a process for triangulating serious incidents in our mental health services and publishing outcomes.
- (k) We will seek to standardise post-incident reviews in line with Greater Manchester
- (l) We recognise the need to build on access to information online and through other means. Greater Manchester are developing an online resource so we will build into our online resources locally including the Life in Tameside and Glossop website.

#### **11.9 Pillar 7: Suicide bereavement support and resources**

- (a) We will develop a Suicide Bereavement Pathway with people with lived experience including consideration of need for group based and 1-1 interventions. This will include
  - The GM wide suicide bereavement service and associated website
  - support offered to families by Pennine Care teams following a suicide of patient

#### **11.10 Pillar 8: Evaluation measures including data collection and evaluation system**

- (a) A SMART Action Plan for 2019/20 is included in **Appendix 1**, the populated version will be updated each year
- (b) We will agree key data and develop a bi-annual review of this to track our progress and use the learning to improve our understanding, our communications, our strategy and our services
- (c) We will support the GM approach to the use of 'Real-Time Data' in maximising our response to suicides.
- (d) We will develop our processes across Tameside and Glossop to foster a culture of learning from suicide attempts and the avoidance of a blame culture

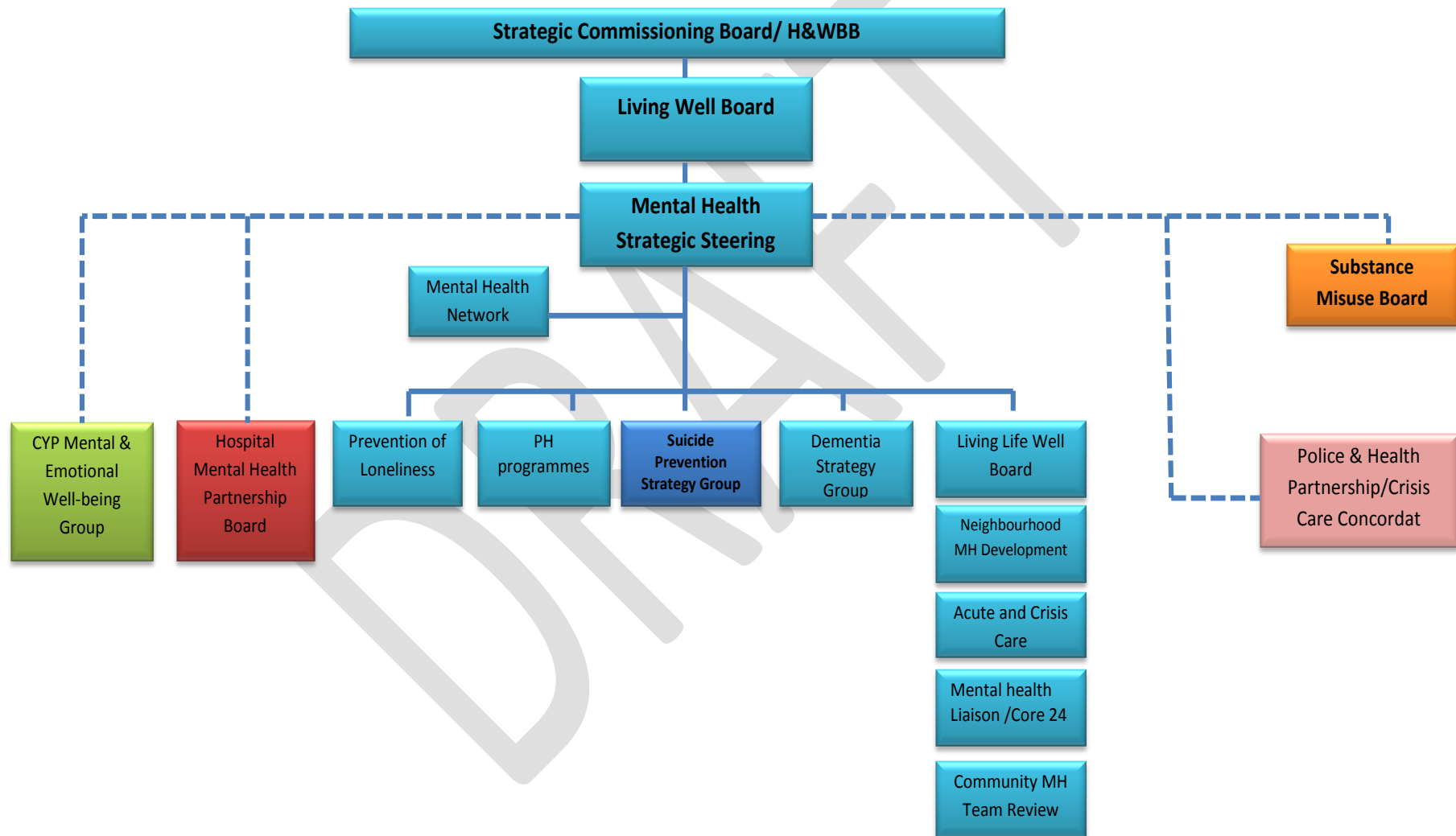
#### **11.11 Pillar 9: Capacity building/sustainability within communities**

- (a) We will consult with community and voluntary sector colleagues about the needs of specific groups such as LGBT, Asylum seekers, those with a Long-term condition, drugs and alcohol treatment clients and individuals in contact with the justice system to identify options for improving outcomes in these groups

### **12. GOVERNANCE INFRASTRUCTURE**

- 12.1 The strategy will be delivered by the Tameside & Glossop Suicide and Self Harm Prevention Group which will identify partners to deliver progress against each work stream. The suicide prevention work stream is closely aligned to the mental health and wellbeing 'Living Life Well' programme of work, the Locality Plan and the One Corporate Plan (**Appendix 3**).
- 12.2 A programme management approach will be utilised to focus on delivery and measurement of impact during 2018/19 and 2019/20 which will form the basis of the work of the Suicide and Self-Harm Prevention Group.

## Tameside and Glossop Mental Health Strategy Governance



## APPENDIX 1: Suicide Prevention Action Plan 2019/20

Number	Objective	Action	By Whom	Timescale
1	To further develop and establish a strong suicide prevention strategy group	a) We will secure a permanent chair to the group, review the membership and terms of reference.	Suicide prevention strategic group	June 1 <sup>st</sup> 2019
		b) The group will send regular reports and strategy implementation updates to the Mental Health Strategic Steering Group		
2	To produce regular reports and briefings to the suicide prevention group, mental health steering group and Health & Wellbeing Board	a) A local suicide audit for Tameside & Glossop will be produced every 5 years and we will contribute to the annual GM audit	Jacqui Dorman	April 1 <sup>st</sup> 2022
		b) We will produce regular briefings to the suicide prevention group regarding the 'Real time' data provision provides via GM	Jacqui Dorman	December 31 <sup>st</sup> 2019
3	To increase suicide prevention awareness	a) We will support and deliver locally the GM and national suicide prevention campaigns	Communication team Tameside & Glossop	a) Spring and Autumn 2019
		b) In partnership with GM we will develop and deliver a social marketing initiative to stimulate a social movement around self-harm and suicide to reduce stigma		b) December 31 <sup>st</sup> 2020
		c) In partnership with GM we will work with local our local media to agree standards for reporting of suicides	Suicide prevention strategy group	c) April 1 <sup>st</sup> 2020

4	To promote mental health and wellness and improve population resilience	a) We will encourage schools to sign up to the 'mentally health schools' programme and school staff will be encouraged to take up the 'zero suicide alliance' e-learning module. We will capture the take up of the e-learning as part of the overall monitoring of take-up of suicide prevention training.	Charlotte Lee (population health)	a) December 31 <sup>st</sup> 2019
		b) A directory of mental health and suicide prevention support and services will be established and maintained through the 'Life in Tameside & Glossop' Web portal	Jacqui Dorman and Arianne Whitley	b) September 30 <sup>th</sup> 2019
		c) We will communicate and promote the services and support available to residents who need help relating to suicide risk area such as debt and money advice, housing, relationships and criminal justice etc.	Jacqui Dorman and Communications Team	c) March 31 <sup>st</sup> 2020
		d) We will undertake a focused piece of work within the Living Life Well Programme with men to understand how best to reach them to promote mental wellbeing.	Arrianne Whitley	d) December 31 <sup>st</sup> 2019
5	To skill up our whole workforce on suicide prevention to help them to be confident to ask/support others	a) We will develop a comprehensive mental health and suicide prevention training ladder that covers the needs of the whole workforce.	a) Pam Watt and Vicky Broadbent	a) June 30 <sup>th</sup> 2019
		b) We will identify the training resources needed and develop/ commission an annual rolling programme	b) Pam Watt and Vicky Broadbent	b) August 31 <sup>st</sup> 2019
6	To increase support for people at risk of suicide	a) We will develop an overnight 'safe haven' for people assessed as requiring immediate support b) We will establish a STORM Pathway within our neighbourhood mental health development for people assessed as needing on-going support. c) We will continue work with GM to develop and roll out the new GM Suicide Bereavement Service and, when operational, review if there are any unmet needs in Tameside and Glossop.	Pat McKelvey and Hayley McGowan	December 31 <sup>st</sup> 2019

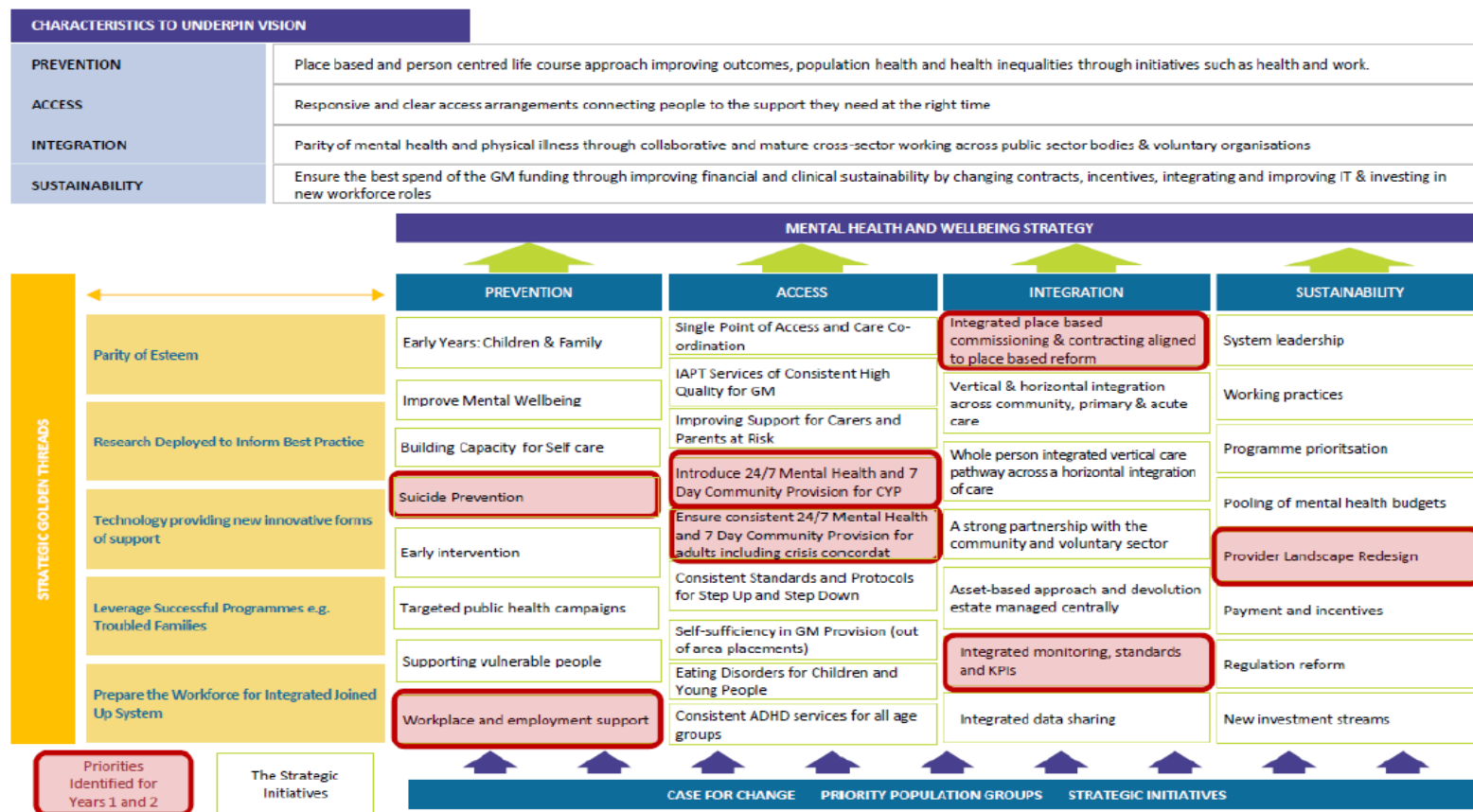


7	To ensure coherence across the system	a) We will undertake an audit on self-harm and from this identify any actions within this strategy. b) We will work with the leads for the Children and Young Peoples Emotional and Mental Health Locality Transformation Plan to ensure coherence with this Strategy	Jacqui Dorman  Kristy Nuttall	a) 31 <sup>st</sup> October 2019  b) 31 <sup>st</sup> July 2019
8	To improve access to Suicide bereavement support and resources	a) We will scope bereavement support options locally with a view to implement a local offer in line with SOBs standards  b) We will implement the Greater Manchester suicide bereavement offer across Tameside & Glossop  c) We will develop a bereavement pathway in relation to the 'real time' GM data to ensure people who need support are signposted to appropriate services and interventions	Suicide prevention strategy group   Jacqui Dorman and Pat McKelvey	a) 31 <sup>st</sup> December 2019  b) June 30 <sup>th</sup> 2019  c) 1 <sup>st</sup> April 2020
9	To evaluate and learn from suicides	a) We will ensure that we learn from suicide and episodes of self-harm through an annual review of serious case reviews, CDOP reports and coroner's reports ensuring recommendations from the review are being implemented. This will also be part of the suicide audit process.  b) we will complete a bi-annual review of the GM real-time data and report to the suicide prevention group	Suicide prevention group  Jacqui Dorman	31 <sup>st</sup> December 2020  31 <sup>st</sup> December 2020
10	To increase capacity building and sustainability within communities	We will work with all our voluntary sector organisations to identify at risk groups within our communities to ensure that suicide prevention is embedded within our high risk populations and that these populations are aware of the help and support available	Suicide prevention group and Action Together	31 <sup>st</sup> December 2020

## APPENDIX 2

### Appendix 1 – Greater Manchester Mental Health Strategy.

#### Compelling Vision Strategic Plan on a Page



## APPENDIX 3

# Transforming Tameside & Glossop Our People – Our Place – Our Plan For everyone every day

### Starting Well

### Living Well

### Ageing Well



### Great Place Vibrant Economy