Suicide: The Preventable Death – Thames Valley Position Statement

Thames Valley Clinical Senate

NHS England and NHS Improvement

Contents

Foreword

Good Mental Health is recognised as being at least as important as physical health. Suicide prevention is a tangible and practical measure of mental health services and is rightly a national NHS England priority. Suicide rates in Thames Valley are lower than the national average but there is always room for improvement. Thames Valley Clinical Senate is pleased to present this report which collates available information on suicide prevention in the local health system, compares this to national data and makes some recommendations for the future planning of local services.

I should like to thank the contributors to this report for their expertise, time and patience in bringing it to fruition.

Dr Jane Barrett OBE

Chair, Thames Valley Clinical Senate

Executive Summary

Suicide has become the biggest killer of middle-aged men. Everyday, on average 13 people die by suicide. Not only is this a loss of life that could be saved, it can also have devastating affects on families, friends, colleagues and communities.

In 2012 the cross-government outcomes strategy, Preventing Suicide in England, set out an aim to reduce suicide and provide better support for those who are bereaved and affected by suicide. The Five Year Forward View for Mental Health (2016) set out a national ambition to reduce the suicide rate in England by 10% by 2020/21. This was to be supported by the roll out of local multi-agency suicide prevention plans.

This report is an amalgamation of national and local suicide data, local rates, risk factors of suicide and how each area within the Thames Valley is performing in comparison to England. A scoping exercise using national strategies to improve mental health services, mental health provision in Primary Care and bereavement services was used to understand national ambitions to prevent suicide. The local system was involved in providing their current position in alignment with the national ambitions and recommendations to prevent suicide.

The report also highlights the work carried out by the Thames Valley Suicide Prevention and Intervention Network that is; locally focused, to prevent suicide, to reduce risk factors of suicide and champion the importance of bereavement support. Future focus of the TV SPIN will include the continued support of the local system in regard to preventing suicide and exploring the relationship between neurodevelopmental disorders, namely Autism and risk of suicide.

After considering local findings, the Senate has made its recommendations accordingly. The Senate acknowledged the important role that mental health and crisis response services play in reducing risk of suicide, especially for those individuals who may not have previously met the criteria for mental health services. More training should be available for frontline NHS staff in suicide prevention, equipping them to manage conversations with those who may be at risk of suicide.

Self-harm and its correlation to suicide should be explored, especially as it has been evidenced that young people are most at risk. The Senate also recommends that as challenges of workforce capacity have an impact on delivery of services and training, this may be a chance to maximise opportunity to link with voluntary organisations.

The Senate report provides a picture of the development of services across the Thames Valley. A snapshot in time of how the local system is working towards preventing suicide and reducing the inequalities and gaps in the mental health and bereavement services. Recommendations are made as to what further work is required to prevent suicide.

1. Introduction

Suicide is preventable, however suicide rates in England increased during 2007-2014. Suicide has become the biggest killer of men aged under 50, as well as being a leading cause of death in young people and new mothers. On average, 13 people kill themselves every day in England. The death of someone by suicide has a devastating effect on families, friends, workplaces, schools and communities, as well as having an economic cost [1].

In 2012 the cross-government outcomes strategy, Preventing Suicide in England, set out a plan aimed at reducing the suicide rate in the general population in England and ensuring better support for those bereaved or affected by suicide. The independent Mental Health Taskforce report, Five Year Forward View for Mental Health (2016)[2], set a national ambition to reduce the suicide rate in England by ten per cent by 2020/21, against the 2016 figure of 4,820 suicides, and for every local area to have in place a multi-agency suicide prevention plan[2]. The ambitions of the Five Year Forward View for Mental Health are supported by NHS England (NHSE) and additional funding has been made available, which is targeted at the most vulnerable populations and areas of greatest risk.

Looking today, progress has been made with most local authorities having a suicide prevention plan in place, and data shows that the suicide rate in England fell by 431 between 2014 and 2017 (from 4,882 to 4,451). Further reductions are required to deliver the targeted 10% reduction of 482 suicides by 2020/21, but trend analysis suggests that numbers of suicides will increase from the low in 2017[3].

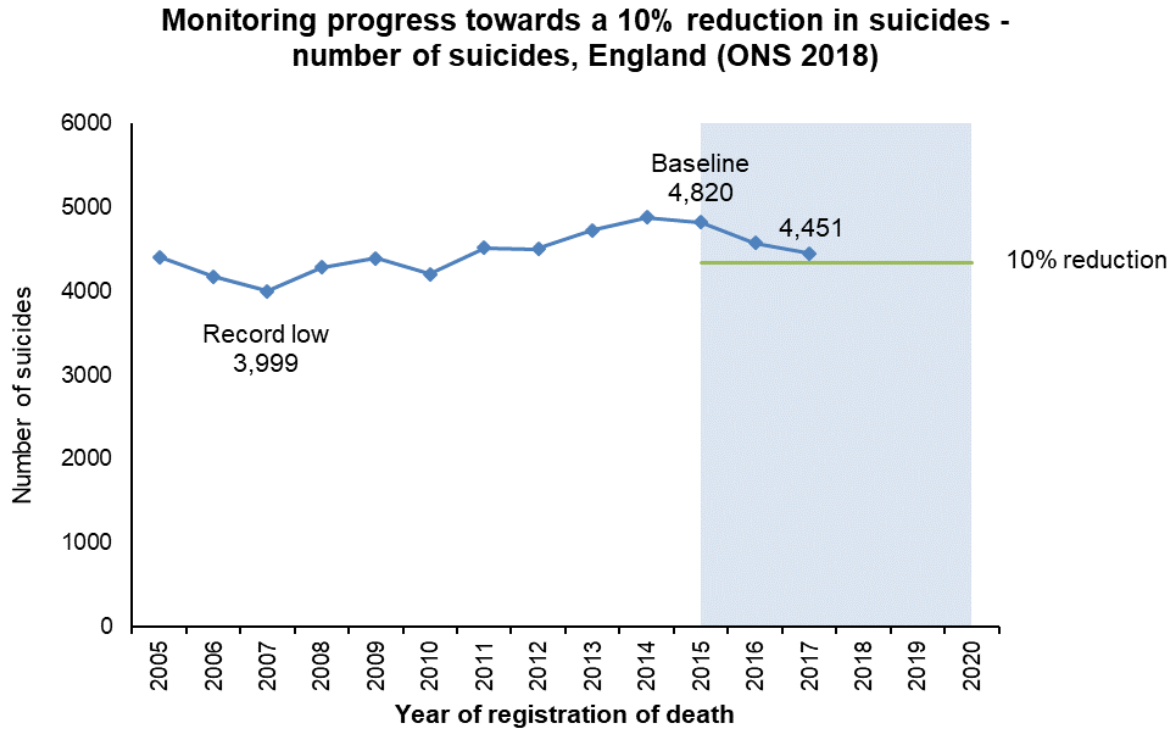


Figure 1: Monitoring progress towards a 10% reduction in suicides
Source: ONS (4 September 2018) Suicides in the UK: 2017 registrations.[4]

The third progress report of the national strategy, published in January 2017[3], refocussed its ambitions on:

- Better and more consistent local planning with every local area having a multi-agency suicide prevention plan in 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 bereavement by suicide and support services; and
- Expanding the scope of the national strategy to include self-harm prevention in its own right.

A high-level review carried out by the Clinical Senate, in liaison with the Thames Valley Strategic Clinical Mental Health Network, identified that considerable work was underway across the Thames Valley in the area of suicide prevention. However, the information wasn't available in a single place, which made it difficult to ascertain what extent expectations were being achieved, and to measure local progress.

The Clinical Senate agreed that it would be helpful if there was a record of the work underway to reduce suicides in Thames Valley, and that this should include a comparison against the requirements set out in the national guidance documents to connect national policy with local delivery and to enable monitoring of progress. The report should recognise good practice and highlight any areas for further attention or development.

2. Suicide – The background

Response to suicide prevention requires a multi-agency approach as risk factors are complicated and include health, social and economic circumstances. Around 25% of mental health patients who die by suicide have a major physical illness (accounting for 3,410 deaths between 2005 and 2013)[3] which highlights the ongoing importance and value of truly integrated mental and physical health services. Due to this, developing suicide prevention plans is the responsibility of local authorities[2]

The table below shows the overlap of the areas of responsibilty for each of these stakeholders and therefore the level of complexity in the Thames Valley.

STP/ICS	BOB STP					Frimley ICS				
Clinical Commissioning Group (CCG)	Buckinghamshire	Oxfordshire	Berkshire West			East Berkshire			Surrey Heath	North East Hampshire & Farnham
Local Area/s	Buckinghamshire	Oxfordshire	Reading	West Berkshire	Wokingham	Slough	Royal Borough of Windsor and Maidenhead	Bracknell Forest	Surrey Heath	North East Hampshire & Farnham
Suicide Prevention Plans	Buckinghamshire Multiagency Suicide Prevention Plan 2017	Oxfordshire Suicide Prevention	DRAFT Berkshire Suicide Prevention Strategy 2017-2020						DRAFT Surrey Suicide Prevention Strategy 2018-2021	
Mental Health Acute Trusts	Oxford Health NHS FT		Berkshire Healthcare NHS FT						Surrey and Borders Partnership NHS FT	
Mental Health Acute Trust Suicide Prevention Plan	OHFT Self-harm and Suicide Prevention Strategy 2018-2021		BHFT Zero Project Plan 2019						Towards Zero Suicide Prevention Plan	
Acute Trusts	Buckinghamshire Healthcare NHS Trust	Oxford University Hospitals NHS Trust	Royal Berkshire Hospital NHS Trust			Frimley Healthcare NHS FT				

Table 1: Overview of the multiagency approach in Thames Valley

2.1 Definition of suicide

Suicide is defined as death from intentional self-harm and events of undetermined intent[4].

In 2016, the Office of National Statistics (ONS) revised its definition of suicide to include deaths from intentional self-harm in children aged 10 to 14, reducing the age of those previously included in the suicide rates data[4]. It is alarming that children as young as ten are dying by intentional self-harm though several reports in recent years have raised concerns about the mental health of young people, suggesting rising rates of emotional problems and self-harm. Self-harm is most common in people under 25 and although suicide rates at this age are comparatively low, the latest figures from 2015 show a small rise[4].

2.2 Risk factors of suicide

Public Health England has published the risk factors of suicide and has undertaken mapping exercises to identify geographical areas of high risk.

The risk factors identified by Public Health England are:[5]

- Depression
- Substance misuse
- Alcohol consumption
- Unemployment
- Older people living alone
- Those bereaved by suicide.

The strategy, Preventing Suicide in England[6], highlighted that 'Suicide is often the end point of a complex history of risk factors and distressing events' and suicides are more likely to occur in areas of low social and economic prosperity, in under-served communities and among those experiencing a range of challenges to their health, employment, finances, social and personal lives.

Using the risk factors, high risk groups have been identified who should be prioritised for prevention support:

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

3. Suicide rates and risk factors – Thames Valley [5]

The latest ONS data shows there have been 522 deaths by suicide in the Thames Valley between 2014 to 2016. Although the number of suicides is decreasing, there are still too many individuals who are dying by an avoidable death.

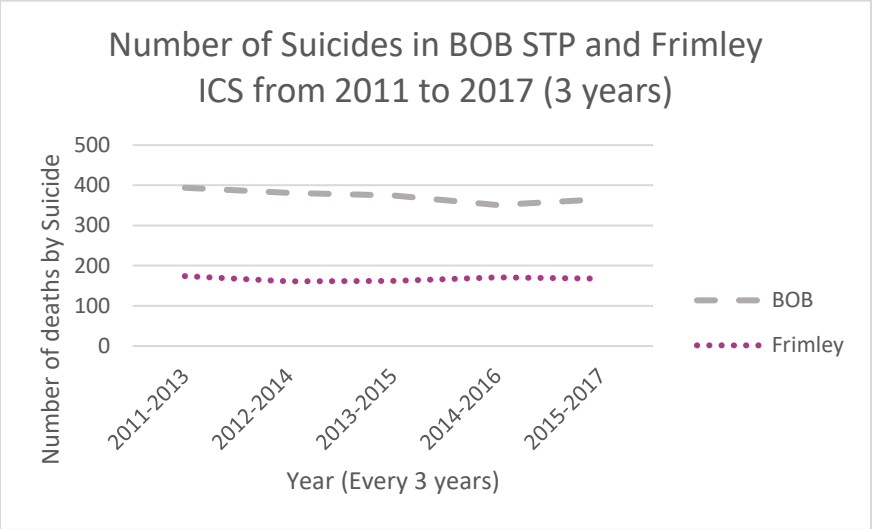


Figure 2: Number of Suicides in BOB STP and Frimley ICS from 2011 to 2017 (Every 3 years)

	Year (3 year average)				
Number of Suicides in all ages	**2011 - 2013**	**2012 - 2014**	**2013 - 2015**	**2014 - 2016**	**2015 - 2017**
England	13758	14122	14429	14277	13846
BOB	394	381	375	351	365
Frimley	174	161	162	171	168

Table 2: Number of Suicides in BOB and Frimley in comparison to England for all ages (3 year average)

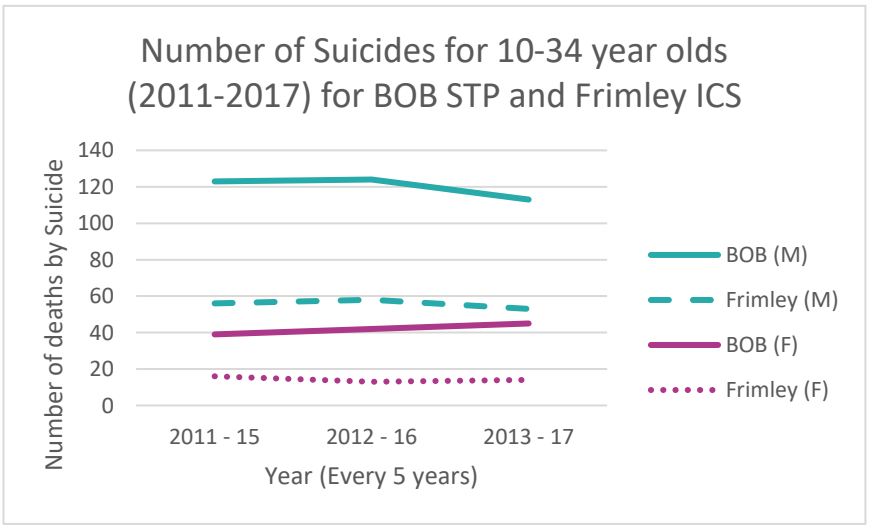


Figure 3: Number of Suicides for 10-34 year olds (2011-2017) for BOB STP and Frimley ICS

Table 3: (below) Number of suicides in BOB and Frimley in comparison with England for the age group of 10-34 year olds from 2011 to 2017 (5 year averages).

Number of Suicides in 10-34 year olds	Year (5 year average)					
	2011 - 2015		2012 - 2016		2013 - 2017	
	Male	Female	Male	Female	Male	Female
England	4556	1255	4643	1275	4595	1342
BOB	123	39	124	42	113	45
Frimley	56	16	58	13	53	14

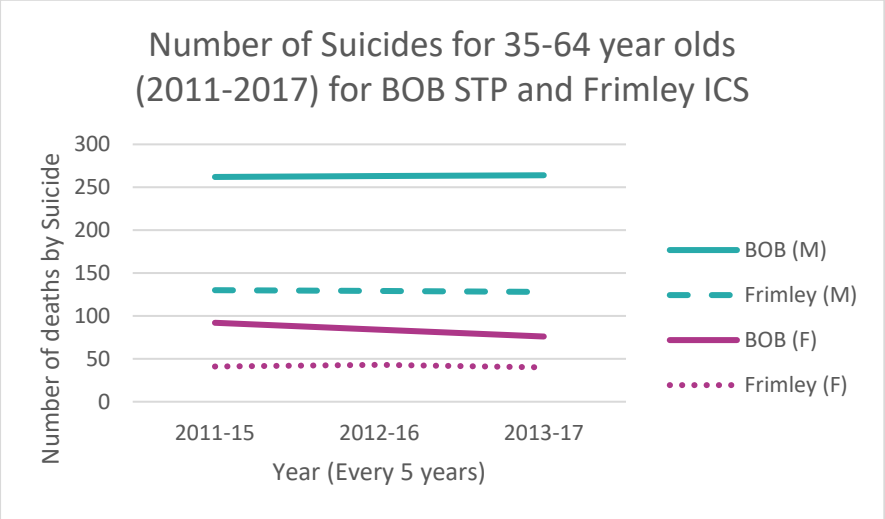


Figure 4: Number of Suicides for 35-64 year olds (2011-2017) for BOB STP and Frimley ICS

Number of Suicides in 35-64 year olds	Year (5 year average)					
	2011 - 2015		2012 - 2016		2013 - 2017	
	Male	Female	Male	Female	Male	Female
England	10723	3177	10634	3189	10465	3175
BOB	262	92	263	84	264	76
Frimley	130	41	129	43	128	40

Table 4: Number of suicides in BOB and Frimley in comparison with England for the age group of 35-64 year olds from 2011 to 2017 (5 year average)

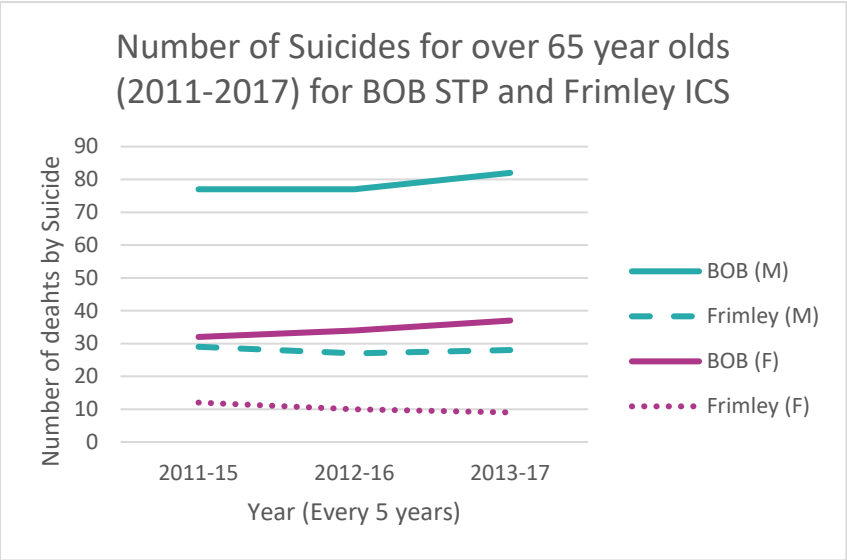


Figure 5: Number of Suicides for over 65 year olds (2011-2017) for BOB STP and Frimley ICS

Number of Suicides in 65+ years	Year (5 year average)					
	2011 - 2015		2012 - 2016		2013 - 2017	
	Male	Female	Male	Female	Male	Female
England	2618	1131	2664	1112	2721	1157
BOB	77	32	77	34	82	37
Frimley	29	12	27	10	28	9

Table 5: Number of suicides in BOB and Frimley in comparison to England for age group of 65 years and over from 2011 to 2017 (5 year average)

3.1 Suicides rates

The rates, particularly for men, are either lower or on a par with the England average. However, the data shows that for women in the 10-34 age group numbers of suicides are increasing and this warrants further attention.

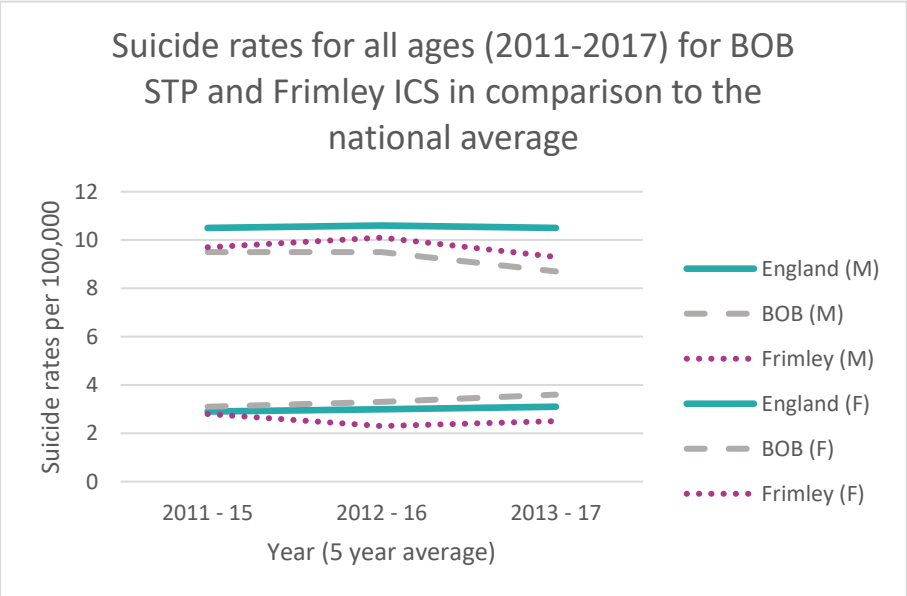


Figure 6: Suicide rates for all ages (2011-2017) for BOB STP and Frimley ICS in comparison to the national average

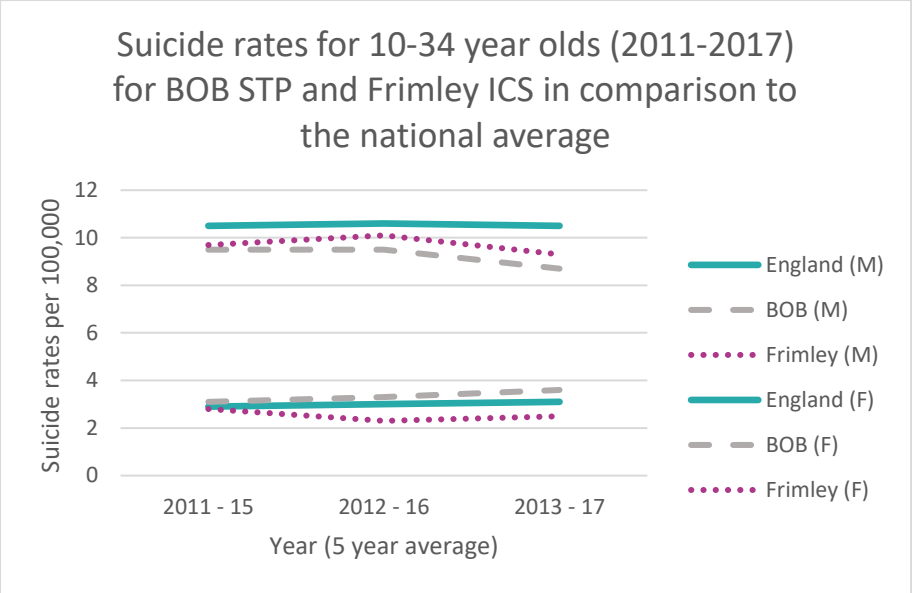


Figure 7: Suicide rates for 10-34 year olds (2011-2017) for BOB STP and Frimley ICS in comparison to the national average

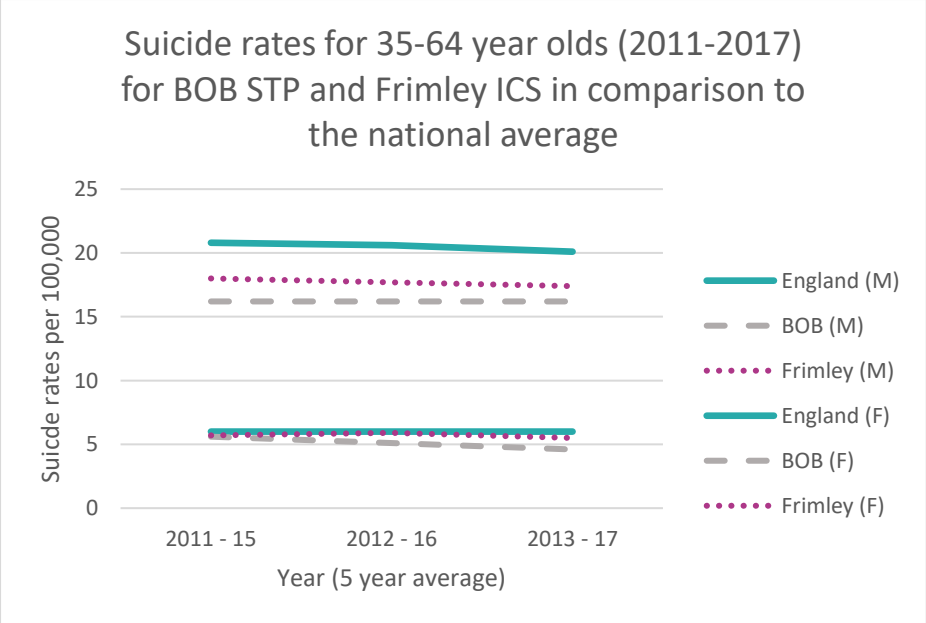


Figure 8: Suicide rates for 35-64 year olds (2011-2017) for BOB STP and Frimley ICS in comparison to the national average

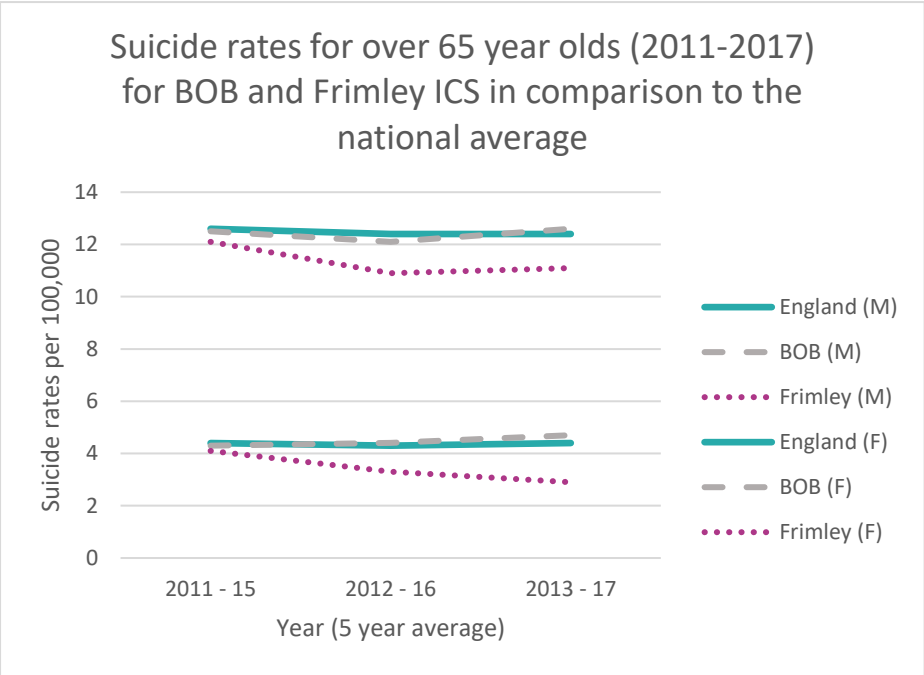


Figure 9: Suicide rates for over 65 year olds (2011-2017) for BOB and Frimley ICS in comparison to the national average

Data taken from Public Health Fingertips: Suicide Prevention Profile.[20]

3.2 Risk factors in the Thames Valley

Using the comparative data provided by PHE on the Fingertips website[5], it is possible to ascertain the level of risk for the Thames Valley population against the key risk factors. (NB: the data for Hampshire and Surrey is only available as a whole county.)

On the whole, Thames Valley has a lower prevalence against each of the risk factors than the England average. Exceptions to this are recorded opiate use which is higher than the England average in Reading and Slough Unitary Authorities, both of which have areas of deprivation that are higher than the rest of the Thames Valley. Oxfordshire, Bracknell Forest and Hampshire have a higher prevalence of recorded depression for those aged 18 or over.

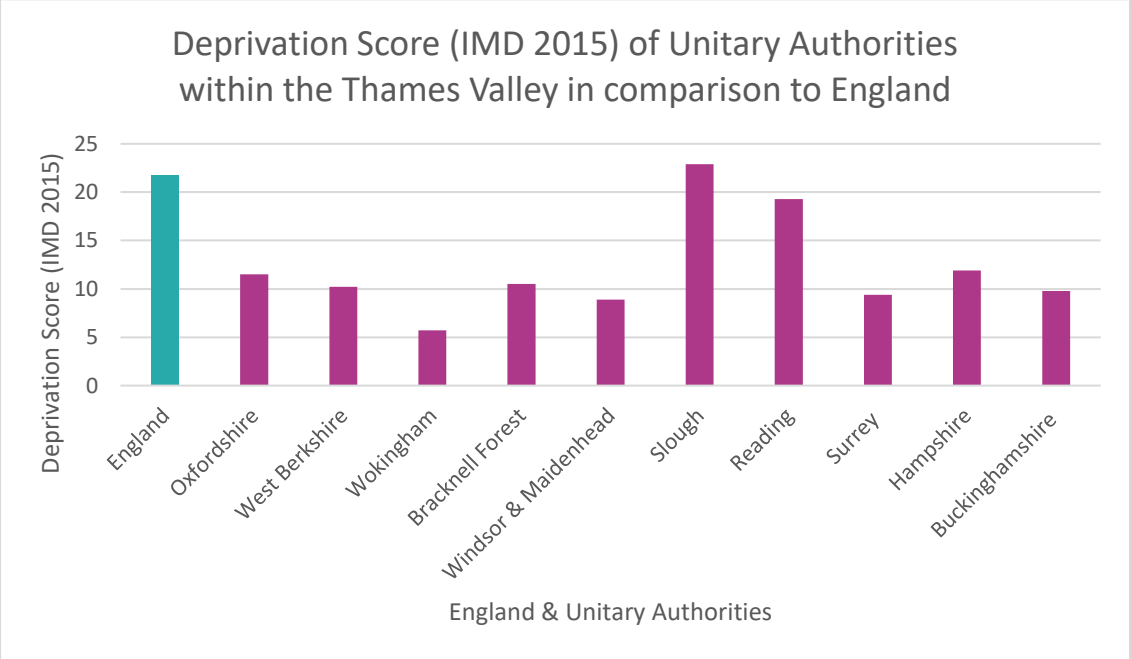
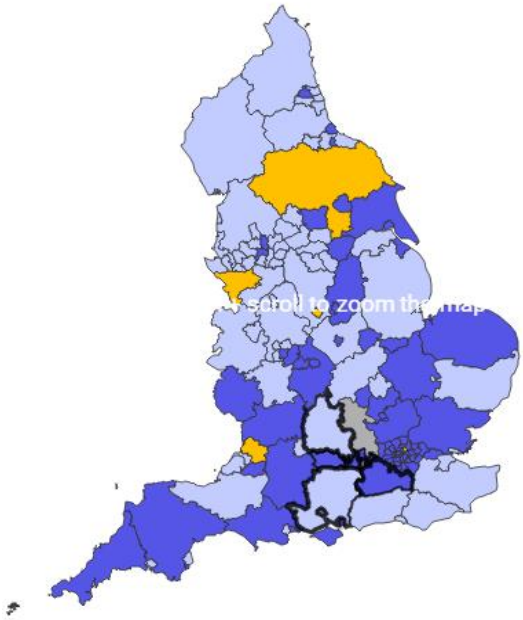


Figure 10: (above): Deprivation score of unitary authorities within the Thames Valley in comparison to England[21]

It is important to note here that the individual districts within Oxford or Buckinghamshire for example vary. Within Buckinghamshire the districts can vary from 9.1 per 100,000 to 4.2 per 100,000. Therefore, whilst reading this graph please note this is not a direct and true comparison's between Unitary authorities.

Figure 11: (below): Map of county and unitary authorities in England for depression: Recorded prevalence (aged 18+) (Proportion-% 2017/18)

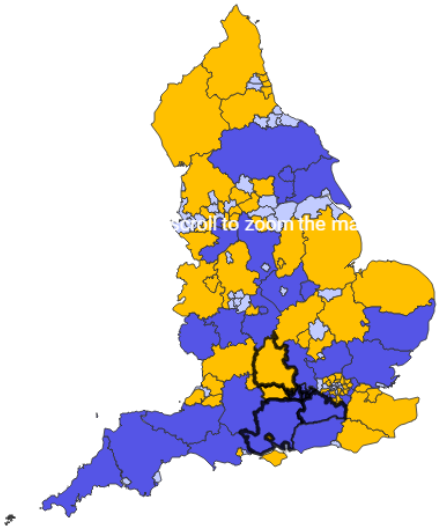
The prevalence of depression in Thames Valley is mostly lower than the England average, with the exception of Oxfordshire, Bracknell Forest and Hampshire.



		per 1000
England average		9.9
Oxfordshire	Higher	10.3
West Berkshire	Lower	9.2
Wokingham	Lower	8.4
Bracknell Forest	Higher	12
Windsor & Maidenhead	Lower	7.8
Slough	Lower	6.9
Reading	Lower	8.3
Surrey	Lower	8.9
Hampshire	Higher	10.9
Buckinghamshire	No Data	

Figure 12: Map of county and unitary authorities in England for estimated prevalence of opiate and/or crack cocaine use (Crude rate – per 1000 2016/17)

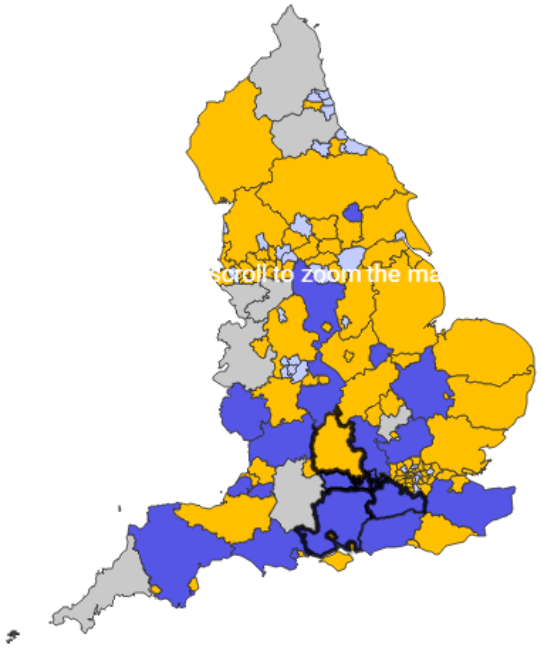
The crude rate of opiate and/or crack cocaine use in Thames Valley is mostly lower than the England average, with the exception of Slough and Reading.



		per 1000
England average		8.9
Oxfordshire	Similar	7.8
West Berkshire	Lower	6.4
Wokingham	Lower	3.6
Bracknell Forest	Lower	4.6
Windsor & Maidenhead	Lower	5.6
Slough	Higher	13.2
Reading	Higher	11.8
Surrey	Lower	4.6
Hampshire	Lower	4.1
Buckinghamshire	Lower	4.5

Figure 13: Map of county and unitary authorities in England for unemployment (Proportion - % 2017)

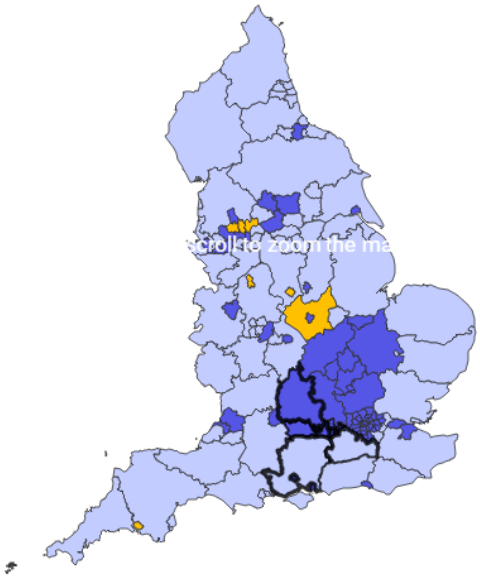
Unemployment in Thames Valley is lower than the England average.



		per 1000
England Average		4.4
Oxfordshire	Similar	3.8
West Berkshire	Lower	2.2
Wokingham	Lower	2.4
Bracknell Forest	Lower	2.8
Windsor & Maidenhead	Lower	2.4
Slough	Lower	3.8
Reading	Lower	3.3
Surrey	Lower	2.4
Hampshire	Lower	2.5
Buckinghamshire	Lower	1.8

Figure 14: Map of county and unitary authorities in England for older people living alone: % of households occupied by a single person aged 65 or over (Proportion - % 2011)

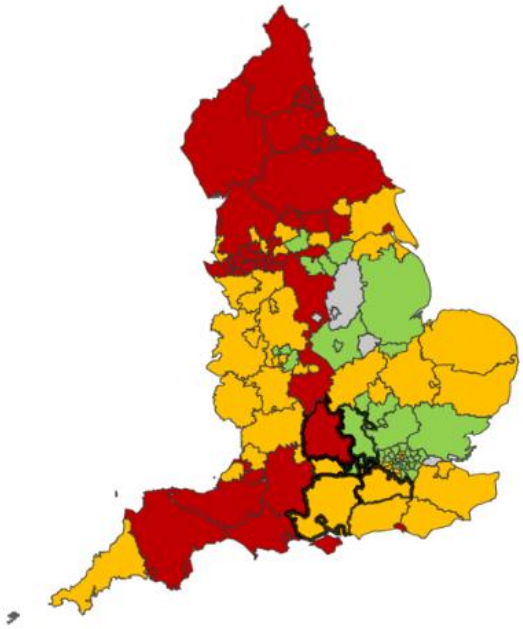
The number of older people living alone in Thames Valley is lower than the England average, with the exception of Hampshire and Surrey, though data is not available to identify whether this is specific to certain areas only.



		per 1000
England Average		12.4
Oxfordshire	Lower	11.5
West Berkshire	Lower	10.9
Wokingham	Lower	10.2
Bracknell Forest	Lower	9.7
Windsor & Maidenhead	Lower	11.9
Slough	Lower	7.9
Reading	Lower	9.5
Surrey	Higher	12.6
Hampshire	Higher	12.6
Buckinghamshire	Lower	11.8

Figure 15: Map of county and unitary authorities in England for admission episodes for alcohol-specific conditions in under 18s (2015/16 – 2017/18)

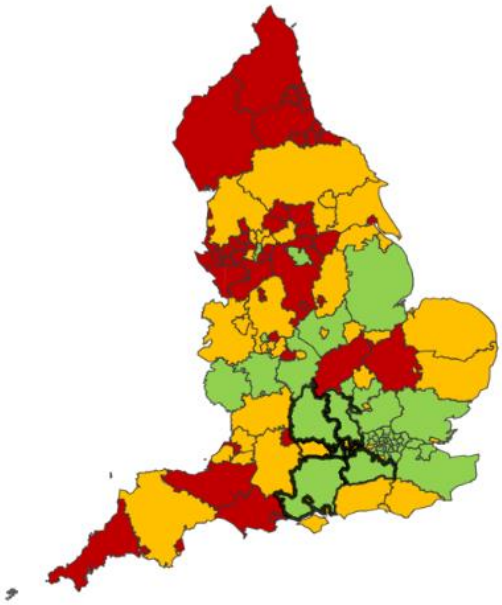
The number of admissions for alcohol-specific conditions in under 18s is lower in Thames Valley than the England average, with the exception of Oxfordshire.



		per 100,000
England average		32.9
Oxfordshire	Higher	40.9
West Berkshire	Similar	34.4
Wokingham	Lower	21.9
Bracknell Forest	Similar	24.9
Windsor & Maidenhead	Lower	21.5
Slough	Lower	16.1
Reading	Similar	31.8
Surrey	Similar	32.7
Hampshire	Similar	30.6
Buckinghamshire	Lower	22.9

Figure 16: Map of county and unitary authorities in England for admission episodes for alcohol-specific conditions in 18-40 year olds (2017/18)

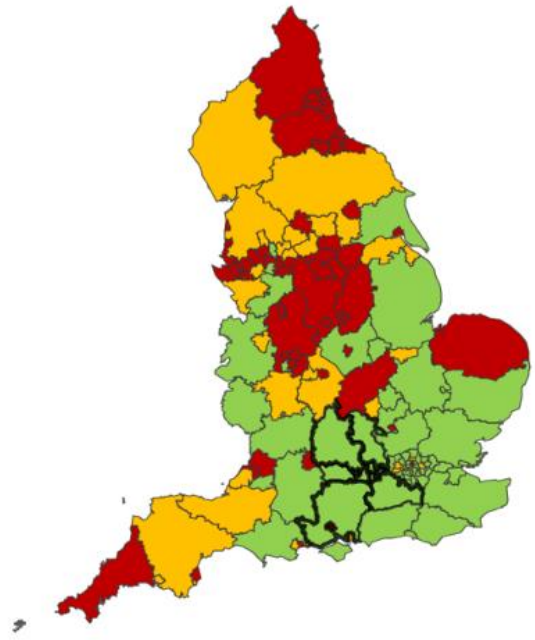
The number of admissions for alcohol-specific conditions in 18-40 year olds is lower in Thames Valley than the England average.



		per 100,000
England average		298
Oxfordshire	Lower	237
West Berkshire	Similar	282
Wokingham	Lower	226
Bracknell Forest	Lower	247
Windsor & Maidenhead	Similar	278
Slough	Similar	283
Reading	Similar	274
Surrey	Lower	254
Hampshire	Lower	273
Buckinghamshire	Lower	239

Figure 17: Map of county and unitary authorities in England for admission episodes for alcohol-specific conditions in 40-64 year olds (2017/18)

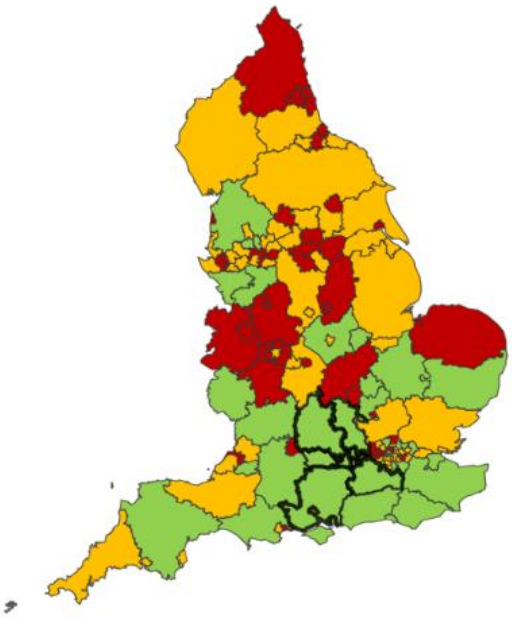
The number of admissions for alcohol-specific conditions in 40-64 year olds in Thames Valley is lower than the England average.



		per 100,000
England average		877
Oxfordshire	Lower	612
West Berkshire	Lower	517
Wokingham	Lower	443
Bracknell Forest	Lower	572
Windsor & Maidenhead	Lower	554
Slough	Similar	835
Reading	Lower	733
Surrey	Lower	620
Hampshire	Lower	584
Buckinghamshire	Lower	717

Figure 18: Map of county and unitary authorities in England for admission episodes for alcohol-specific conditions in over 65s (2017/18)

The number of admissions for alcohol-specific conditions in over 65s in Thames Valley is lower than the England average.



		per 100,000
England average		1016
Oxfordshire	Lower	762
West Berkshire	Lower	713
Wokingham	Lower	713
Bracknell Forest	Lower	803
Windsor & Maidenhead	Lower	835
Slough	Similar	1003
Reading	Lower	818
Surrey	Lower	845
Hampshire	Lower	802
Buckinghamshire	Lower	906

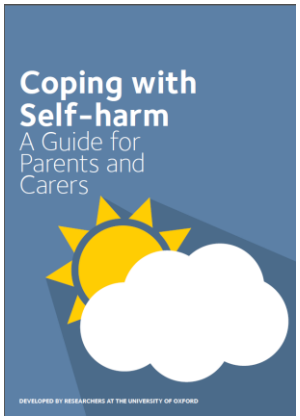
3.3 Self-harm

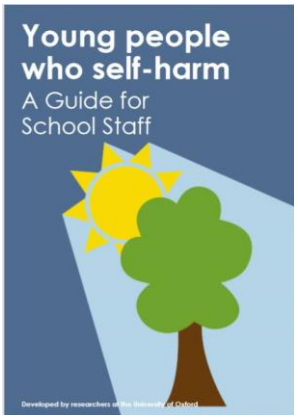
The fourth progress report of the national suicide prevention strategy, Preventing Suicide in England, now has a focus on self-harm as a new risk factor and is looking at self-harm prevention in its own right[3].

Self-harm, including attempted suicide, is the single biggest indicator of suicide risk. Approximately 50% of people who have died by suicide have a history of self-harm and in many cases, there has been an episode of self-harm shortly before someone takes their own life[3].

- 20% of patients reported to have self-harmed will repeat and return to the same hospital within a year
- Up to 1% will die by suicide in the year after self-harm
- 50% of people dying by suicide have history of self-harm and 15% will have presented to hospital for self-harm in the year before their death.

Those who self-harm should be added to the high-risk groups for targeted intervention and prevention support.





In 2015, a team from Oxford University's Centre for Suicide Research launched a guide to help parents and carers who are trying to cope and support a child who self-harms[7]. The guide was developed based on research on self-harm and interviews with parents.

Most recently in 2018 Oxford University's Centre for Research launched a self-harm guide for school staff[8]. Both guides aim to provide parents/carers and school staff with ways in which they can support those who self-harm.

The guides include information on what self-harm is, how to approach the individual who is self-harming, helpful questions and statements, confidentiality, and how to manage the immediate effects of self-harm. The importance of disseminating these guides as widely as possible has been highlighted by Professor Hawton, a leading national expert on suicide.

3.4 The impact of suicide

Suicide has a devastating impact on families, friends, communities and work colleagues. People who have lost a loved one or somebody they knew can be at an increased risk of mental health and emotional problems[9]. Where it was once considered that around six people are affected for every suicide, new research has found that it could be up to 135 people[10].

Patient suicide can also have an adverse impact on clinicians and Professor Keith Hawton, Consultant Psychiatrist and Director at University of Oxford Centre, advised that research is underway to assess

impact of suicide on clinicians and how support for them can be improved. In the interim, Oxford Health NHS Foundation Trust and Berkshire Healthcare NHS Foundation Trust have a psychological debriefing service provided by clinicians to clinicians. This is currently provided on a voluntary basis due to a lack of resource.

Help is at Hand[11] is a guide designed to help and support those that are bereaved by suicide. Dissemination of this guide is one the ways that families and friends bereaved by suicide in the Thames Valley are supported and can continue to be supported.

The guide is free and available to all family members, friends and colleagues that have been bereaved by suicide. The different sections of the guide take the reader through the stages of bereavement, feelings and the importance of acknowledging these feelings, the processes of the police and coroners, how different people will be affected dependent on who they have lost (e.g. partner, siblings or friends), and how individuals can help someone else who has been bereaved by suicide. The guide also considers the role of culture and faith and emphasises the importance of talking to someone about their feelings.

The Little Blue Book of Sunshine[19] is a booklet that has been co-produced with young people and the Clinical Commissioning Groups in the east of Berkshire. The booklet is a help guide made specifically for young people. This booklet has been delivered to every secondary school in Slough, Bracknell, Ascot and Windsor for pupils aged 14 and above.

The booklet includes information for young people regarding negative and/or stressful feeling, how these feelings might manifest, and what support is available. The booklet encourages young people to seek help if they want support and/or need someone to talk to.

The support information at the end of the booklet is specific to East Berkshire, however the helplines and websites provided throughout the booklet are national. Therefore, the resource is open and available for all areas to use.

4. Review of work in Thames Valley

There are a number of key national guidance and strategy documents relating to suicide prevention and mental health support which highlight key aspects of service delivery with timescales for achievement. The intention of these guidance documents is to ensure that services in England are in the best possible position to support suicide prevention and deliver the reduction in suicides by 2020/21. The key documents used to assess the current state in Thames Valley are:

- The Five Year Forward View for Mental Health (2016)[2]
- Implementing the Five Year Forward View for Mental Health (2016)[12]
- Mental Health Crisis Care Concordat (2016)[13]
- GP Five Year Forward View (2017)[14]
- Support after a suicide – A guide to providing local services (PHE) (2018)[15]
- NHS CQUIN Guidance for 2019-2020[16]
- Cross-Government Suicide Prevention Workplan (2019)[17]

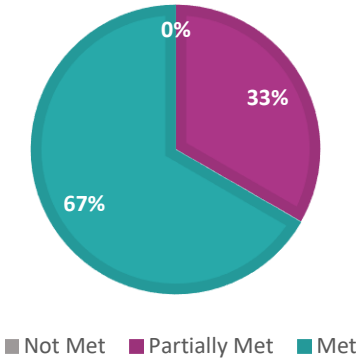
Service recommendations set out in these documents were used as a baseline which was collated and disseminated electronically to all CCGs and mental health trusts in the Thames Valley for an accuracy check. The information reviewed and edited by the CCGs and mental health trusts was used to amalgamate the results within this report. Results are shown at high level and record the extent to which the guidelines are being met.

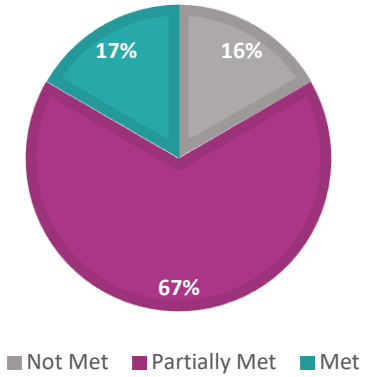
Clinical Commissioning Groups (CCGs)	Mental health trusts
Buckinghamshire	Oxford Health NHS Foundation Trust
Oxfordshire	
Berkshire West	Berkshire Healthcare NHS Foundation Trust
East Berkshire	
Surrey Heath	Surrey and Borders Partnership NHS Foundation Trust
North East Hampshire and Farnham	

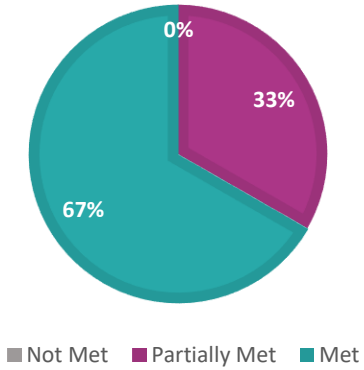
Table 2: Alignment of CCGs to mental health trusts

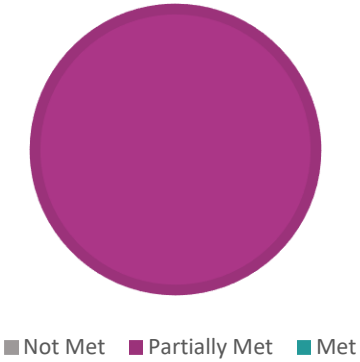
5. Results

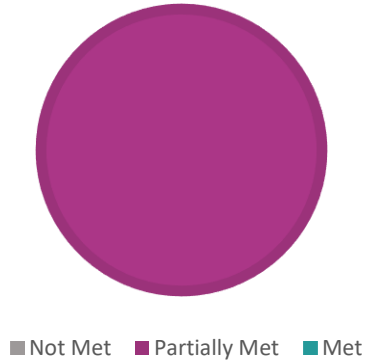
<table>
<tr><th>No.</th><th>Service/Recommendation</th><th>Service/Recommendation met</th></tr>
<tr><td>1</td><td>Crisis Resolution Home Treatment Teams (CRHTTs) need to be available 24 hours of the day, seven days a week, need to be able to assess and treat, need to be to support/respond to crisis and should be community-based to be able to access patients at their home.

To be achieved by 2020/21</td><td> 
</td></tr>
<tr><td colspan="3">Only some areas of Thames Valley have a CRHTT in place for adults and older adults. In these areas, teams are able to provide assessment and treatment in the community (at the patients' home) 24/7. The population of Berkshire is able to self-refer into the team as well as having a professional referral. For those patients who are referred as an emergency by the GP there is a four-hour target to be assessed. Some areas within the Thames Valley only partially meet this service recommendation. For example, whilst Oxfordshire has a team in place that offers home assessment, it does not have a separate, fully functioning CRHTT with current support being provided via the community mental health team. Buckinghamshire is able to provide assessments out of A&E, out of hours and provide home treatment. Additional funding within Buckinghamshire has been agreed for 2019/2020 and 2020/2021 for crisis care, with particular focus on delivering CRHTT in line with the FYFV ambition. It is a priority for Oxford and Buckinghamshire to put in place a team that is able to offer both assessment and treatment at home 24/7.</td></tr>
</table>

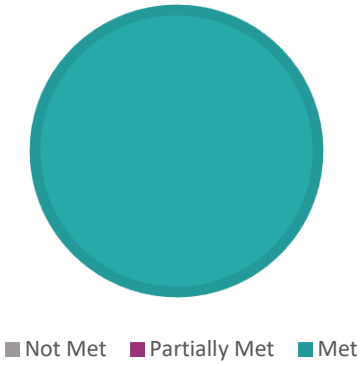
1a	Equivalent model of CRHTTs for children and young people (CYP). To be achieved by 2020/21	
Many areas do not yet have a fully functioning CRHTT model for CYP. Those areas that do not meet and/or partially meet the service recommendation provide only limited support for CYP within office hours. Some teams offer additional hours, providing support on Saturdays and bank holidays. The one area within Thames Valley that has met this service recommendation is Oxfordshire. Oxfordshire CAMHS provides an out of hours service for urgent emergencies. This service is available 24/7, 365 days per year. Buckinghamshire partially meets the service recommendation as the CAMHS Outreach Service for Children and Adolescents (OSCA) is able to offer home treatment during the day. There is some on call provision for out of hours. Other areas within the Thames Valley are able to provide limited in-hours support to CYP however there is no dedicated CRHTT model in place.		

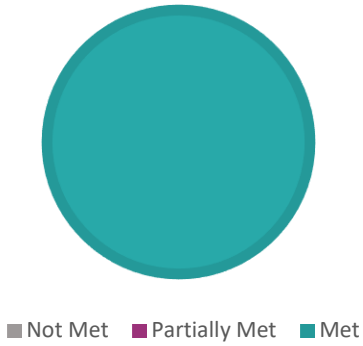
2	Acute liaison in emergency departments and inpatient wards: An all-age mental health liaison service should be available in all acute hospital emergency departments and inpatient wards and at least 50% should meet the Core 24 standard To be achieved by 2020/21	
Mental health support provided in emergency departments and inpatient wards is provided in all areas within Thames Valley. However, in some areas there is only limited support for CYP in inpatient wards and none that is 24/7. The majority of areas within the Thames Valley are able to provide mental health support in emergency departments and inpatient wards. This is mostly provided via the mental health trust teams. Oxfordshire also has BIRCH. This service supports young people who present to the A&E at the John Radcliffe (Oxford University Hospitals NHS Foundation Trust) with self-harm.		

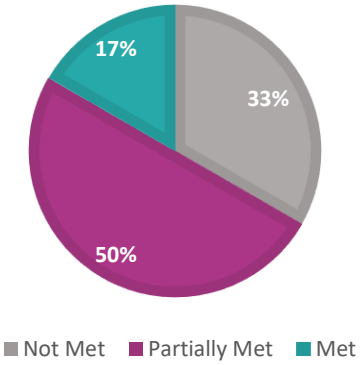
3	Acute care models (16-25s) are inpatient services supporting young people. The environment should maximise opportunities for rehabilitation, return to education, training or employment. Should build on new models of 'transitional' services for those aged 0-25 years. Acute care models for 16-25s to be trialled in 2016 however no timeline for when they should be in place by	
There are inpatient/community services available for individuals up to 18 years and then beyond, however there are no age-specific inpatient/community services for 16-25 year olds. There are discussions with regard to 0-25 year old service provision as part of the Long Term Plan. However, this is still in the early stages of discussion.		

4	Step-down support should be provided from secure care (residential rehabilitation, supported housing and forensic or assertive outreach teams). Local funding to be released in 2020/21 in order to mainstream previously trialled step-down support (Trials to have taken place using £38 million funding held centrally from 2017/18 to 2020/21)	

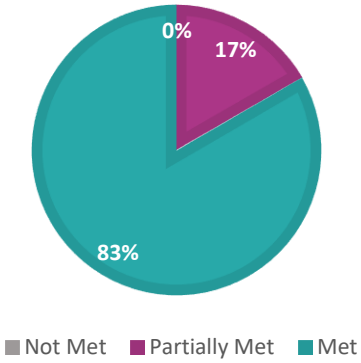
Most of the Thames Valley is covered by the Forensic New Care Models. Led by Oxford Health and with the inclusion of seven other mental health trusts (Berkshire Healthcare Foundation Trust is one of the seven) and Response, a housing charity, the Thames Valley and Wessex Forensic Network aim to deliver care focused on individual patient need, reduce the number of people being placed in a hospital far away from their home and families, and enable more people to be successfully discharged into the community. There is step-down support available from high secure inpatients, to low secure inpatients and pre-discharge. Although the whole pathway is included, the support available at each stage of step-down is limited. Aspects of step-down, such as housing, are a social care provision. North East Hampshire and Farnham and Surrey Heath CCG have delegated commissioning arrangements with Surrey and Borders Partnership Foundation Trust, who manage the step-down pathway and access the appropriate support through the independent sector. Similar to acute care models (see service/recommendation three) there are services available, however they are not age specific to the 16-25 year age range.

5	Local authority suicide prevention plans in place. To be in place by end of 2017	
All local authorities within Thames Valley have a local suicide prevention strategy in place that covers the key areas of focus as recommended nationally. The strategies also included local information and data to make them relevant to their area.		

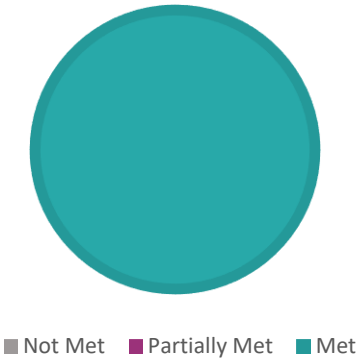
6	Trust suicide prevention plans in place. To be in place by end of 2018/19	
There are three mental health trusts that provide mental health support to the population of Thames Valley. All three have a prevention plan in place: • Oxford Health Foundation Trust (OHFT Self-harm and Suicide Prevention Strategy 2018-2012) • Berkshire Healthcare Foundation Trust (BHFT Zero Project Plan 2019) • Surrey and Borders Partnership Foundation Trust (Towards Zero Suicide Prevention Plan inclusive of Zero Suicides in Inpatients)		

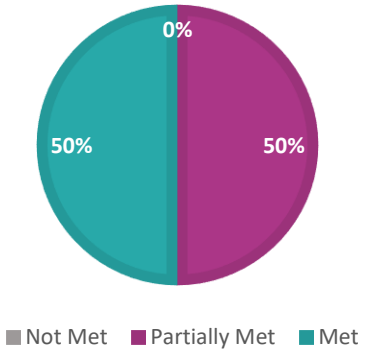
7	Integration of primary care in supporting mental health patients – mental health support worker placed at GP surgery. To be achieved by 2020/21	

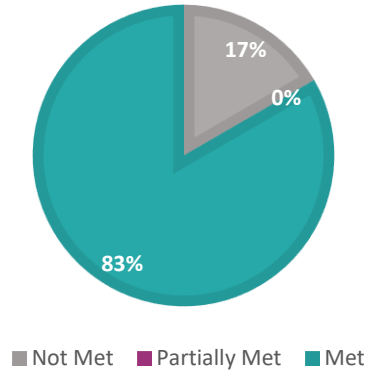
Every practice in Buckinghamshire has a link mental health worker and a link psychiatrist, who is not based in primary care but is able to provide mental health support. Other areas have limited mental health support within their GP surgeries. This is either provided via Improving Access to Psychological Therapies (IAPT) workers or local mental health trust teams. Some areas are still piloting mental health support workers in a limited number for GP surgeries. The number of mental health support workers in primary care and whether they are recurrently funded differs from area to area. Due to the new and emerging primary care networks (PCN) areas are considering how primary care can be supported at a PCN level in regard to mental health.

7a	Primary care education for suicide prevention (inclusive of suicidal risk). To be achieved by 2020/21	

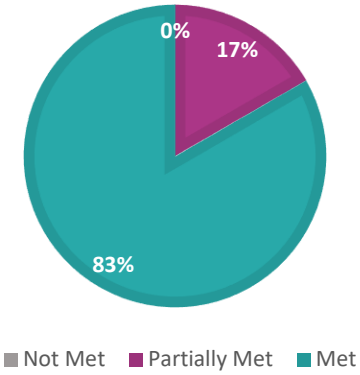
All CCGs within Thames Valley have offered suicide prevention training to primary care. This training has been offered via many different avenues; face to face, evening training and online training. All CCGs have future plans regarding how training will be offered and provided to those who work in primary care. In comparison to other areas Surrey Heath has not provided as much training, and at the moment has limited future plans for suicide prevention training due to a vacant training officer post. Although all areas offer suicide prevention training it is not always taken up by GPs. There is also limited training available for other primary care staff and feedback from the CCGs has identified a difficulty for practice staff in identifying patients who are potentially at risk of suicide through their behaviours e.g. struggling with alcohol or drug use.

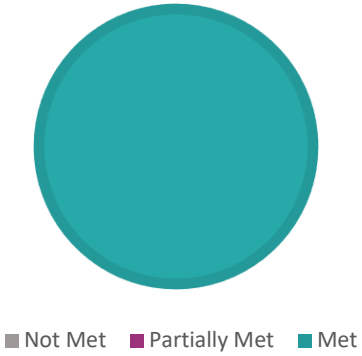
8	Out of hours mental health services (24/7) mental health support to be provided out of hours. To be achieved by 2020/21	
All areas within Thames Valley provide some sort of out of hours (OOH) mental health support. This can either be accessed physically or via telephone. In addition to OOH mental health services there are also commissioned safe havens that individuals can attend if they need mental health support. The amount of support available differs from area to area. Some areas provide separate helplines for CYP, adults and older adults, others offer 24/7 all age helpline and Berkshire has a police street triage crisis provision for seven nights a week.		

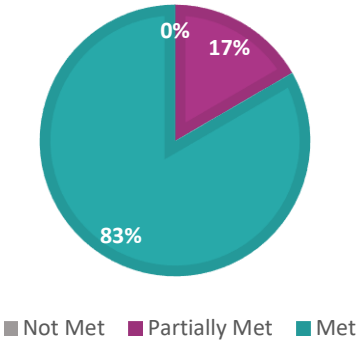
9	Adult community mental health services: timely access to evidence-based, person-centred care, which should focus on recovery and should integrate with primary care, social care and other sectors. To be achieved by 2020/21	
All areas within the Thames Valley have an adult/community mental health team in place. The waiting time for these services differs, from 28 days to 11 to 18 weeks for a routine appointment. Therefore, not all adult mental health teams within Thames Valley meet the service recommendation of timely access to evidence-based therapy. Areas that do meet the service recommendation provide same day appointments for emergencies, an appointment within 5-7 days for urgent referrals and an appointment within 28 days for routine cases.		

10	Real-Time Suicide Surveillance System (RT SSS): Collecting data in real time. Both health and social care to integrated to provide support to those affected. No deadline	

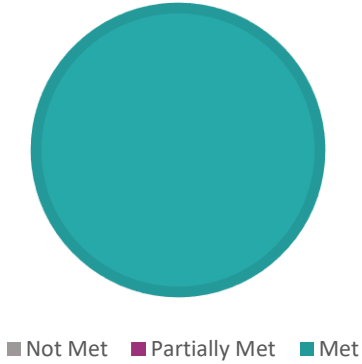
All but one area within the Thames Valley has an RT SSS. Surrey Health are currently working towards bringing together a working group, so they can start to implement an RT SSS in their area. In the rest of the Thames Valley the RT SSS is under the supervision of the local police force.

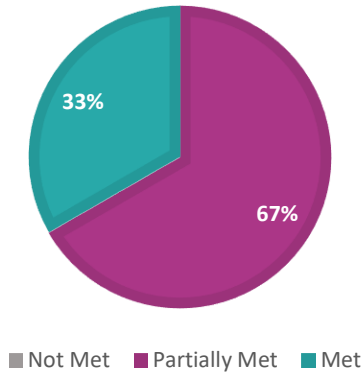
11	Bereavement: First contact – police, coroner and coroners' office, funeral director, primary care, self-referral. No deadline	
Those areas that have RT SSS in place have fully met the service recommendation to have a first contact when someone dies by suicide. The member of police staff that has the responsibility of supervising the RT SSS in this case also provides first contact bereavement support to the families of those who have lost someone by suicide. As Surrey Heath does not yet have a RT SSS in place it is unclear how bereaved families are supported. If the police are first informed of the death, they will contact the family. Alternatively, it may be the coroner. However, the support provided to the population of Surrey Heath will not be equivalent to the support provided by an identified individual whose role includes bereavement support, as is the case for the other areas within Thames Valley.		

12	Bereavement referral to postvention service: Local service providers (national and local charities/organisations). No deadline	
All areas within the Thames Valley have services available that health professionals can to refer into, or that the individuals who have been bereaved can refer themselves into. These are known bereavement charities providing support across Thames Valley. These services are also signposted by those who are the first contact for the bereaved families.		

13	Bereavement: Face to face meeting – Contact with trained and experienced teams or individuals, child death overview panel, local safeguarding board. No deadline	

The majority of areas within the Thames Valley are able to provide their population with face to face support. In Surrey Heath initial bereavement support is limited as there is no RT SSS in place and therefore no dedicated individual in post. Bereaved families and friends can be referred via their GP to a secondary care mental health service (experienced teams) and have access to voluntary bereavement charities.

14	Bereavement: Additional support – primary care, mental health services, schools, youth groups, faith groups, funeral directors, welfare support, housing providers/support. No deadline	
The whole of Thames Valley has bereavement support via additional services. National charities such as the Samaritans, Cruse, SOBS and local safe havens are all available to provide individual or group support to those who have been bereaved. Geographically these services are located in many different areas ensuring accessibility for service users. The importance of bereavement support services has been highlighted by Professor Hawton and the Help is at Hand guide. Initial scoping of bereavement support services found that it was not always easy to find them listed in an accessible way, making it harder for the population and other professionals to find and signpost these services to someone who has been bereaved by suicide.		

15	NHS CQUIN – Achieving 50-80% of adult mental health inpatients receiving a follow-up within 72 hours of discharge. To be achieved by quarter 3/4 of 2019/20	
There are three mental health trusts providing support within the Thames Valley. Oxford Health Foundation Trust are already providing their discharged patients with a 48 hour follow up. Both Berkshire Healthcare NHS Foundation Trust and Surrey and Borders Partnership NHS Foundation Trust are working towards rolling out a 72 hour follow up in quarter three of 2019/2020.		

6. Summary

The survey showed that Thames Valley does provide its population with mental health support, however there is still more that can be done. Good progress is being made against the services/recommendations though there are a couple of areas where performance is falling short.

The Five Year Forward View for Mental Health and the cross-government suicide prevention workplan emphasised the need to have consistent suicide prevention plans in place for local areas and mental health trusts. All local authorities in the Thames Valley now have suicide prevention plans that reflect the key areas specified in national guidance. One of the three mental health trusts have not achieved the timeline for production of a suicide prevention plan for their inpatients and whilst it is reported that it is working to deliver this, a timescale for completion is not known.

'Improving the 7-day crisis response service across the NHS will help save lives'. A fully functioning CRHTT should be able to provide assessment and treatment to individuals in the community 24/7. More than 60% of the Thames Valley provides a fully functioning 24/7 CRHTT ahead of the target date of 2020/21. The only area that does not have a named crisis team in place to date, is prioritising this. Areas that do not have a fully functioning team are still able to provide some limited crisis support for its adult population.

In comparison, around 80% of the Thames Valley does not currently provide the same crisis support for CYP. Areas that do provide crisis support for CYP do so in a limited way, with some only able to offer support in office hours and others extending this to Saturdays and bank holidays. Only one area within the Thames Valley has a CRHTT for CYP that supports the young population 24/7. The alternative provision is A&E.

The integration of mental health support in primary care is not equal across Thames Valley. Not all surgeries within Thames Valley have a mental health worker in place to support GPs and nurses. In the areas that do there is limited support with a limited number of mental health workers providing support to several surgeries. These mental health workers are provided via IAPT or local mental health trusts. Looking forward, CCG areas in Thames Valley are planning to integrate mental health support workers into their new primary care network (PCN) models.

Suicide awareness and prevention training is offered to primary care, specifically GPs across the whole of Thames Valley by dedicated trainers, psychiatrists and psychologists. Areas such as Oxfordshire, Berkshire and Buckinghamshire have been able to offer more training in comparison to Surrey Heath. This is due to a vacant training officer post.

Suicide prevention training is offered primarily by the CCG however there are also other free resources and tools available to be used by primary care staff. All CCGs have included suicide prevention training in their primary care education plans for 19/20.

Acute care models (inpatient/community support for 16-25s) and step-down support are both services that are not yet available across the Thames Valley. There is limited step-down support for those up to 18 years of age in Oxfordshire, Buckinghamshire and Berkshire but nothing for those aged 18-25s. There are discussions about a service provision for 0-25 year olds but as of yet there are no published plans.

Mental health support is provided for all adults who are inpatients at acute trusts or A&E. However, not all Trusts provide 24/7 support for CYP. As part of good practice, the Oxford Health team that provide support to A&E at the John Radcliffe will follow up with young people who present to the service with self-harm.

Findings from the National Confidential Inquiry into Suicide and Safety in mental health found that the highest number of suicides in mental health inpatients occurred on day three post-discharge. A new CQUIN has been offered to incentivise each mental health trust to achieve a 72 hour follow up after discharge for 50-80% of their adult mental health inpatients by the quarter 3/4 of 19/20. In Thames Valley, one mental health trust works towards a 48 hour follow up post-discharge. The other mental health trusts are working towards achieving a 72 hour follow up post-discharge by quarter three of 2019/20.

The provision of bereavement services is also important in preventing suicide, as those bereaved by suicide are at a higher risk of dying by suicide themselves. All areas within the Thames Valley have bereavement support and services in place. However, services are not always easily navigable online making it harder for the population to identify what bereavement support is available.

All but one area has a functioning RT SSS in place to ensure suicides are recorded when they take place, to provide real time data and to assist in the identification of potential suicide clusters. It enables prompt response from the police to the bereaved.

The importance of suicide prevention is reiterated in the NHS Long Term Plan (2019). Improving young people's mental health services, transition into adulthood for people aged 18-25 and single point of access and timely, universal mental health crisis care for everyone, are still priorities within the NHS Long Term Plan to reduce the number suicides. NHS have committed to designing a new Mental Health Safety Improvement Programme, which will have a focus on suicide prevention and reduction for mental health inpatients. New milestones have been set for mental health services for adults, to be achieved by 2023/24[24].

6.1 Some examples of good practice in Thames Valley

Thames Valley – Suicide Prevention and Intervention Network (TV-SPIN)

The TV-SPIN is an informal body that draws its membership from all areas of Thames Valley and Milton Keynes, including: Local authority suicide prevention leads, mental health trust leads (clinical), police, NHS England and Improvement, Public Health England, suicide/suicide prevention researchers/experts and representatives from the Thames Valley Strategic Clinical Mental Health Network.

TV-SPIN has been running for many years and after a pause it re-emerged in March 2019. The TV-SPIN provides a unique birds-eye view across all local authorities within the Thames Valley, while also being able to provide updates from the regional and national perspective. It helps support the implementation of the Local Authority Suicide Prevention Plans and facilitates shared learning through regular meetings. These meetings are also used to review the real-time suicide surveillance data for the patch.

The TV-SPIN and the Thames Valley Strategic Clinical Mental Health Network play an important role in organising and bringing together the different multi-agency groups.

6.2 Areas for future focus

Neurodevelopmental disorders

Although not yet an area of focus, a relationship between neurodevelopmental disorders and suicide has been identified. Autistica's report on early death in autism, Personal Tragedies, Public Crisis highlights the risk of suicide in autistic adults who also have a learning disability[18]. Research has shown autistic adults without a learning disability are nine times more likely to die from suicide[18]. After heart disease, suicide is the leading cause of death in autistic adults without a learning disability[18]. Multiple studies suggest that between 30% and 50% of autistic people have considered suicide[25].

Autistica's report makes recommendations for the government and the NHS to establish a National Autism and Morality Review and commit to improved data collection, fund research and develop clear and specific plans to prevent early death in autism[18]. The TV-SPIN and Thames Valley Strategic Clinical Mental Health Network are keen to understand the relationship between autism and suicide within the Thames Valley and how this can be prevented. This is in addition to continuing to focus on preventing suicide by improving mental health services and social care services for everyone.

Personality disorder

It has been shown that a number of people with emotionally unstable (borderline) personality disorders (PD) die by suicide[22]. Some people with PD self-harm regularly in a non-lethal way, accounting for 9% of mental health related visits to emergency departments. Around 24% of people attending GP consultations suffer from PD. A significant gap in skills training around PDs for GPs and other practice staff has been identified. This will be addressed by additional training in 2019/20 for 20 practices across the BOB STP.

With the support of the Thames Valley Strategic Clinical Mental Health Network, TV SPIN has been successful in bidding for funds from NHSE:

1. Postvention bereavement services: to fund bereavement liaison coordination and support roles across BOB. It will increase the capacity of the existing local RT SSS to provide brief listening and support interventions and efectively signpost bereaved individuals to relevant local support agencies.

2. Trailblazer funding

   This bid will fund a number of integrated projects including:
   - Creation of an evidenced-based biopsychosocial assessment for self-harm for use in general hospitals across Thames Valley

- Develop a training and supervision model for provision of brief interventions for people assessed to be at risk of self-harm. To be delivered in OHFT
- Create digital self-monitoring of mood and self-harming behaviour for those in outpatient settings who have chosen not to access onward secondary mental health services. To be delivered in OHFT
- For those who choose to be seen by the secondary care mental health services, access to a mood monitoring and safety planning app. To be delivered in BHFT
- End of project conference to present projects and their outcomes.

7. Recommendations/Conclusions

It is evident that the Thames Valley is responding well to the guidance relating to increasing suicide prevention support to its population. There are pockets of good practice and others where more focus is required. The risk factors in Thames Valley are comparatively low which should mean that a lower suicide rate is achievable. In some aspects, particularly for young and middle aged men, the data shows that Thames Valley is doing well. However, of concern is the growth in suicides amongst women and particularly in the 10-34 year old group. The lack of consistent service for younger people is therefore something which should be prioritised for attention.

1. The Senate report provides a picture of the development of services across the Thames Valley and should be used to monitor both future developments and gaps.
2. The data shows there is a small increase in suicides amongst older people (over 65s) in BOB STP. This should be kept under close review.
3. There is new focus on self-harm and its direct correlation to suicide. Young people are most at risk and the review has evidenced that there are no dedicated inpatient or community services for 16-25 year olds. This should be addressed.
4. The challenges of workforce capacity have an impact on efforts to deliver services and training in this important area, as in others, and may need creative responses maximising the links with voluntary organisations.
5. The review of services identified that mental health support in primary care is inconsistent and in some cases lacking. The development of the primary care networks is an opportunity to look at how this is provided in the future and the Clinical Senate recommends that this is taken forward as a priority.
6. Feedback from the CCG primary care mental health leads suggests that more training should be available and encouraged for frontline NHS staff to enable them to feel able to manage conversation with people who may be at risk of suicide. Staff availability should be considered before training is organised and offered.
7. Staff should be encouraged to take and share information regarding a person's potential suicide risk with and from friends and family where appropriate and in line with the guidance set out in the Consensus Statement[23].
8. Provision should be made for crisis support for suicidal individuals, especially those not meeting criteria for mental health services, including in primary care.

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Appendix 1: National Recommendations/targets, service recommendations/targets for suicide prevention and the National Guidance documentation

National Guidance Document	Service/Recommendations to implement that will reduce risk of suicide/death by suicide	Description/Requirement of Service
The Five Year Forward View for Mental Health	Crisis Services - Crisis Resolution and Home Treatment Teams (CRHTTs)	CRHTTs to be in place across England to ensure a 24/7 community-based mental health crisis response is in all areas and that these teams are adequately resourced to offer intesive home treatment as an alterntative to an acute inpatient admission. For children and young people, an equivalent model of care shoulf be developed within this expansion programme.
The Five Year Forward View for Mental Health	Acute Liaison - mental health liason in emergency departments and inpatient wards	No acute hospital should be without all-age mental health liason services in emergency departments and inpatient wards. At least 50% of acute hospitals should be meeting the 'core 24' service standard as a minimum
The Five Year Forward View for Mental Health	Acute Care models for 16-25s	To trial a new model of acute inpatient care for young adults aged 16-25 in 2016, working with Vanguard sites. Inpatient services supporting young people in an environment that maximises oppurtunities for rehabilitation and return to education, training or employment. This should build on the existing trials of new models of 'transitional' services those aged 0-25.
The Five Year Forward View for Mental Health	Step-down support	More 'step-down' help should be provided from secure care, such as residential rehabilitation, supported housing and forensic or assertive outreach teams. Population-based budgets should be in place by April 2017 for those CCGs who wish to commission specialised services for people of all ages.
The Five Year Forward View for Mental Health	Suicide Prevention Plans	Every area should develop a multi-agency suicide prevention plan
Cross-government suicide prevention workplan	Trust Suicide Prevention Plans	Ensuring every mental health trust has a zero-suicide ambition plan for mental health inpatients by the end of 2018/19;
The Five Year Forward View for Mental Health	Mental Health Services - Out of Hours	Services operating Out of Hours to provide mental health support
Mental Health Crisis Care Concordat The Five Year Forward View for Mental Health GP Five Year Forward View	Integration of Primary Care in supporting Mental health patients *inclusive of GP Education*	Providing a mental health professional and hosting a social worker in a GP surgery
Implementing the Five Year Forward View for Mental Health	Out of Hours Mental Health Services	Mental Health support should be available 24/7
The Five Year Forward View for Mental Health	Adult Community Mental Health Services	Will provide timely access to evidence-based, person-centred care, which is focused on recovery and integrated with primary and social care and other sectors
Support after a Suicide - A guide to providing local services (PHE)	Real Time Surviellance	Real time-surveliance model is recommended to ensure there is not a delay in identifying indviduals that need postvention support
Support after a Suicide - A guide to providing local services (PHE)	Services to support those bereaved by suicide - First Contact	Police, Coroner and coroners' office, Funeral Directors, Primary Care & Self referral
Support after a Suicide - A guide to providing local services (PHE)	Services to support those bereaved by suicide - Referral to postvention support service	Local Service providers, for example local and national charities/organisations (Cruse Bereavement, SOBS)
Support after a Suicide - A guide to providing local services (PHE)	Services to support those bereaved by suicide - Face to Face meeting	Trained and experienced team or individual, Child death overview panel, Local Safegaurding boards
Support after a Suicide - A guide to providing local services (PHE)	Services to support those bereaved by suicide - Additional Support	Primary care, Mental health services, Schools, Youth groups, Faith groups, Funeral directors, Welfare Support, Housing providers/support
Commissioning for Quality and Innovation (CQUIN)	NHS CQUIN - follow up after discharge	Achieving 80% of adult mental health inpatients receiving a follow-up within 72 hours of discharge

Appendix 2: RAG Rating for Buckinghamshire CCG against the chosen suicide prevention recommendations/targets

No.	Standard	Not Met	Partially Met	Met
1	Crisis Resolution Home Treatment Teams (CRHTTs) - need to be available 24 hours of the day 7 days a week, need to be able to assess and treat, need to be to support/respond to crisis and should be community based to be able to access patients at their home			
1a	There should be an equivalent model of CRHTTs for Children and Young People			
2	Acute Liaison in Emergency Departments and Inpatient Wards – all-age mental health liaison service should be available in all acute hospital emergency departments and inpatient wards and at least 50% should meet the Core 24 standard			
3	Acute Care Models (16-25s) – inpatient services supporting young people, the environment should maximise opportunities for rehabilitation, return to education, training or employment. Should build on new models of 'transitional' services for those aged 0-25 years			
4	Step-down support – should be provided from secure care (residential rehabilitation, supported housing and forensic or assertive outreach teams)			
5	Local Authority Suicide Prevention Plans in Place			
6	Trust Suicide Prevention Plans in Place			
7	Integration of Primary Care in supporting Mental Health patients – mental health support worker placed at GP surgery. Primary Care education in suicide prevention			
7a	Primary Care Education for suicide prevention (inclusive of suicidal risk)			
8	Out of Hours Mental Health Services (24/7) – mental health support to be provided out of hours			
9	Adult Community Mental Health Services – timely access to evidence based, person centred care, should focus on recovery and should integrate with primary care, social care and other sectors			
10	Real-Time Suicide Surveillance – collecting data in real time. Both health and social care to integrated to provide support to those affected			
11	Bereavement: First Contact – Police, Coroner and Coroners' office, funeral director, primary care, self-referral			
12	Bereavement Referral to postvention service – Local service providers (national and local charities/organisations)			
13	Bereavement: Face to face meeting – Contact with trained and experienced teams or individual, Child Death Overview Panel, Local Safeguarding board			
14	Bereavement: Additional Support – Primary Care, Mental Health Services, Schools, Youth Groups, Faith Groups, Funeral Directors, Welfare Support, Housing providers/support			
15	NHS CQUIN – Achieving 80% of adult mental health inpatients receiving a follow-up within 72 hours of discharge			

Appendix 3: RAG Rating for Berkshire West CCG against the chosen suicide prevention recommendations/targets

No.	Standard	Not Met	Partially Met	Met
1	Crisis Resolution Home Treatment Teams (CRHTTs) - need to be available 24 hours of the day 7 days a week, need to be able to assess and treat, need to be to support/respond to crisis and should be community based to be able to access patients at their home			
1a	There should be an equivalent model of CRHTTs for Children and Young People			
2	Acute Liaison in Emergency Departments and Inpatient Wards – all-age mental health liaison service should be available in all acute hospital emergency departments and inpatient wards and at least 50% should meet the Core 24 standard			
3	Acute Care Models (16-25s) – inpatient services supporting young people, the environment should maximise opportunities for rehabilitation, return to education, training or employment. Should build on new models of 'transitional' services for those aged 0-25 years			
4	Step-down support – should be provided from secure care (residential rehabilitation, supported housing and forensic or assertive outreach teams)			
5	Local Authority Suicide Prevention Plans in Place			
6	Trust Suicide Prevention Plans in Place			
7	Integration of Primary Care in supporting Mental Health patients – mental health support worker placed at GP surgery. Primary Care education in suicide prevention			
7a	Primary Care Education for suicide prevention (inclusive of suicidal risk)			
8	Out of Hours Mental Health Services (24/7) – mental health support to be provided out of hours			
9	Adult Community Mental Health Services – timely access to evidence based, person centred care, should focus on recovery and should integrate with primary care, social care and other sectors			
10	Real-Time Suicide Surveillance – collecting data in real time. Both health and social care to integrated to provide support to those affected			
11	Bereavement: First Contact – Police, Coroner and Coroners' office, funeral director, primary care, self-referral			
12	Bereavement Referral to postvention service – Local service providers (national and local charities/organisations)			
13	Bereavement: Face to face meeting – Contact with trained and experienced teams or individual, Child Death Overview Panel, Local Safeguarding board			
14	Bereavement: Additional Support – Primary Care, Mental Health Services, Schools, Youth Groups, Faith Groups, Funeral Directors, Welfare Support, Housing providers/support			
15	NHS CQUIN – Achieving 80% of adult mental health inpatients receiving a follow-up within 72 hours of discharge			

Appendix 4: RAG Rating for East Berkshire CCG against the chosen suicide prevention recommendations/targets

No.	Standard	Not Met	Partially Met	Met
1	Crisis Resolution Home Treatment Teams (CRHTTs) - need to be available 24 hours of the day 7 days a week, need to be able to assess and treat, need to be to support/respond to crisis and should be community based to be able to access patients at their home			
1a	There should be an equivalent model of CRHTTs for Children and Young People			
2	Acute Liaison in Emergency Departments and Inpatient Wards – all-age mental health liaison service should be available in all acute hospital emergency departments and inpatient wards and at least 50% should meet the Core 24 standard			
3	Acute Care Models (16-25s) – inpatient services supporting young people, the environment should maximise opportunities for rehabilitation, return to education, training or employment. Should build on new models of 'transitional' services for those aged 0-25 years			
4	Step-down support – should be provided from secure care (residential rehabilitation, supported housing and forensic or assertive outreach teams)			
5	Local Authority Suicide Prevention Plans in Place			
6	Trust Suicide Prevention Plans in Place			
7	Integration of Primary Care in supporting Mental Health patients – mental health support worker placed at GP surgery. Primary Care education in suicide prevention			
7a	Primary Care Education for suicide prevention (inclusive of suicidal risk)			
8	Out of Hours Mental Health Services (24/7) – mental health support to be provided out of hours			
9	Adult Community Mental Health Services – timely access to evidence based, person centred care, should focus on recovery and should integrate with primary care, social care and other sectors			
10	Real-Time Suicide Surveillance – collecting data in real time. Both health and social care to integrated to provide support to those affected			
11	Bereavement: First Contact – Police, Coroner and Coroners' office, funeral director, primary care, self-referral			
12	Bereavement Referral to postvention service – Local service providers (national and local charities/organisations)			
13	Bereavement: Face to face meeting – Contact with trained and experienced teams or individual, Child Death Overview Panel, Local Safeguarding board			
14	Bereavement: Additional Support – Primary Care, Mental Health Services, Schools, Youth Groups, Faith Groups, Funeral Directors, Welfare Support, Housing providers/support			
15	NHS CQUIN – Achieving 80% of adult mental health inpatients receiving a follow-up within 72 hours of discharge			

Appendix 5: RAG Rating for North East Hampshire and Farnham CCG against the chosen suicide prevention recommendations/targets

No.	Standard	Not Met	Partially Met	Met
1	Crisis Resolution Home Treatment Teams (CRHTTs) - need to be available 24 hours of the day 7 days a week, need to be able to assess and treat, need to be to support/respond to crisis and should be community based to be able to access patients at their home			
1a	There should be an equivalent model of CRHTTs for Children and Young People			
2	Acute Liaison in Emergency Departments and Inpatient Wards – all-age mental health liaison service should be available in all acute hospital emergency departments and inpatient wards and at least 50% should meet the Core 24 standard			
3	Acute Care Models (16-25s) – inpatient services supporting young people, the environment should maximise opportunities for rehabilitation, return to education, training or employment. Should build on new models of 'transitional' services for those aged 0-25 years			
4	Step-down support – should be provided from secure care (residential rehabilitation, supported housing and forensic or assertive outreach teams)			
5	Local Authority Suicide Prevention Plans in Place			
6	Trust Suicide Prevention Plans in Place			
7	Integration of Primary Care in supporting Mental Health patients – mental health support worker placed at GP surgery. Primary Care education in suicide prevention			
7a	Primary Care Education for suicide prevention (inclusive of suicidal risk)			
8	Out of Hours Mental Health Services (24/7) – mental health support to be provided out of hours			
9	Adult Community Mental Health Services – timely access to evidence based, person centred care, should focus on recovery and should integrate with primary care, social care and other sectors			
10	Real-Time Suicide Surveillance – collecting data in real time. Both health and social care to integrated to provide support to those affected			
11	Bereavement: First Contact – Police, Coroner and Coroners' office, funeral director, primary care, self-referral			
12	Bereavement Referral to postvention service – Local service providers (national and local charities/organisations)			
13	Bereavement: Face to face meeting – Contact with trained and experienced teams or individual, Child Death Overview Panel, Local Safeguarding board			
14	Bereavement: Additional Support – Primary Care, Mental Health Services, Schools, Youth Groups, Faith Groups, Funeral Directors, Welfare Support, Housing providers/support			
15	NHS CQUIN – Achieving 80% of adult mental health inpatients receiving a follow-up within 72 hours of discharge			

Appendix 6: RAG Rating for Oxfordshire CCG against the chosen suicide prevention recommendations/targets

No.	Standard	Not Met	Partially Met	Met
1	Crisis Resolution Home Treatment Teams (CRHTTs) - need to be available 24 hours of the day 7 days a week, need to be able to assess and treat, need to be to support/respond to crisis and should be community based to be able to access patients at their home			
1a	There should be an equivalent model of CRHTTs for Children and Young People			
2	Acute Liaison in Emergency Departments and Inpatient Wards – all-age mental health liaison service should be available in all acute hospital emergency departments and inpatient wards and at least 50% should meet the Core 24 standard			
3	Acute Care Models (16-25s) – inpatient services supporting young people, the environment should maximise opportunities for rehabilitation, return to education, training or employment. Should build on new models of 'transitional' services for those aged 0-25 years			
4	Step-down support – should be provided from secure care (residential rehabilitation, supported housing and forensic or assertive outreach teams)			
5	Local Authority Suicide Prevention Plans in Place			
6	Trust Suicide Prevention Plans in Place			
7	Integration of Primary Care in supporting Mental Health patients – mental health support worker placed at GP surgery. Primary Care education in suicide prevention			
7a	Primary Care Education for suicide prevention (inclusive of suicidal risk)			
8	Out of Hours Mental Health Services (24/7) – mental health support to be provided out of hours			
9	Adult Community Mental Health Services – timely access to evidence based, person centred care, should focus on recovery and should integrate with primary care, social care and other sectors			
10	Real-Time Suicide Surveillance – collecting data in real time. Both health and social care to integrated to provide support to those affected			
11	Bereavement: First Contact – Police, Coroner and Coroners' office, funeral director, primary care, self-referral			
12	Bereavement Referral to postvention service – Local service providers (national and local charities/organisations)			
13	Bereavement: Face to face meeting – Contact with trained and experienced teams or individual, Child Death Overview Panel, Local Safeguarding board			
14	Bereavement: Additional Support – Primary Care, Mental Health Services, Schools, Youth Groups, Faith Groups, Funeral Directors, Welfare Support, Housing providers/support			
15	NHS CQUIN – Achieving 80% of adult mental health inpatients receiving a follow-up within 72 hours of discharge			

Appendix 7: RAG Rating for Surrey Heath CCG against the chosen suicide prevention recommendations/targets

No.	Standard	Not Met	Partially Met	Met
1	Crisis Resolution Home Treatment Teams (CRHTTs) - need to be available 24 hours of the day 7 days a week, need to be able to assess and treat, need to be to support/respond to crisis and should be community based to be able to access patients at their home			
1a	There should be an equivalent model of CRHTTs for Children and Young People			
2	Acute Liaison in Emergency Departments and Inpatient Wards – all-age mental health liaison service should be available in all acute hospital emergency departments and inpatient wards and at least 50% should meet the Core 24 standard			
3	Acute Care Models (16-25s) – inpatient services supporting young people, the environment should maximise opportunities for rehabilitation, return to education, training or employment. Should build on new models of 'transitional' services for those aged 0-25 years			
4	Step-down support – should be provided from secure care (residential rehabilitation, supported housing and forensic or assertive outreach teams)			
5	Local Authority Suicide Prevention Plans in Place			
6	Trust Suicide Prevention Plans in Place			
7	Integration of Primary Care in supporting Mental Health patients – mental health support worker placed at GP surgery. Primary Care education in suicide prevention			
7a	Primary Care Education for suicide prevention (inclusive of suicidal risk)			
8	Out of Hours Mental Health Services (24/7) – mental health support to be provided out of hours			
9	Adult Community Mental Health Services – timely access to evidence based, person centred care, should focus on recovery and should integrate with primary care, social care and other sectors			
10	Real-Time Suicide Surveillance – collecting data in real time. Both health and social care to integrated to provide support to those affected			
11	Bereavement: First Contact – Police, Coroner and Coroners' office, funeral director, primary care, self-referral			
12	Bereavement Referral to postvention service – Local service providers (national and local charities/organisations)			
13	Bereavement: Face to face meeting – Contact with trained and experienced teams or individual, Child Death Overview Panel, Local Safeguarding board			
14	Bereavement: Additional Support – Primary Care, Mental Health Services, Schools, Youth Groups, Faith Groups, Funeral Directors, Welfare Support, Housing providers/support			
15	NHS CQUIN – Achieving 80% of adult mental health inpatients receiving a follow-up within 72 hours of discharge			