Appendix B

The Pan Berkshire Suicide Prevention Strategy 2022-2027 V.15

Consultation Draft

TRIGGER WARNING:

This document discusses deaths from Suicide and related agendas.

Given the sensitivity of the issues raised by the SP agenda please note that the following may be distressing to the reader.

People feeling distressed by this subject are advised to reach out for support to people in their lives who they can discuss this with or seek support via NHS 111 or local Voluntary and Community Services including the Samaritans or Amparo.

Contents

1 Version Control

Version	Outline	Date	Author
Version 13.00	Draft strategy developed by in 2021 developed with the support of the Pan Berkshire Suicide Prevention Steering Group and wider Partnership.	October 2021	Karen Buckle, Katie Badger, Rachel Johnson, Janette Searle, and Sarah Shildrick
Version 14	Refreshed Draft strategy building upon their preceding 13 versions and updating content to reflect system changes	12th December 2022	Dan Devitt Senior Public Health Strategist Berkshire West Public Health
Version 15	Refresh following Summit to ensure the Draft is structurally clear	14th December 2022	Dan Devitt Senior Public Health Strategist Berkshire West Public Health

2 Suggested Refresh and Renewal Cycle

Refresh and Renewal Actions	Frequency	Owner
Annual light review to update	Annual	Pan Berkshire SP Partnership
Full Review of the Strategy, Priorities and Outcomes – with Public and Professional Consultation	In December 2027 – Full Review and refresh	Pan Berkshire SP Partnership

3 Explanatory Note for the Consultation Draft

This Consultation Draft has been generated to help the Pan Berkshire Suicide Prevention Partnership set out its strategic approach to supporting Local Area and Pan Berkshire Suicide Prevention following the Pan Berkshire Suicide Prevention Summit held on Monday the 12th December 2022.

Alongside this a public and professional consultation will be shared across each Berkshire Local Authority from December 2022 onwards to ensure that all Local Areas can feed into the draft and help refine it across all six local authority areas and progress sign off by each LA in Berkshire.

We hope that you will recognize and applaud the wide range of works underway and join us in revising, strengthening and sharing the Strategy across Berkshire to make it a stronger and more impactful. Please send all comments, queries and suggestions to: Dan.Devitt@Reading.gov.uk

4 Acknowledgements

This consultation draft draws heavily on an initial draft completed in late 2021 by Karen Buckle, Katie Badger, Rachel Johnson, Janette Searle, and Sarah Shildrick. In this work they were strongly and ably supported by the **Berkshire Suicide Prevention Steering Group** and the **Berkshire Suicide Prevention Partnership** (See Appendix A)

Its refresh and the creation of this Consultation Draft would have not been possible without the strong foundations laid down by them all, and to them all credit for this strategy is due.

5 Definitions

Attempted suicide: Act of self-poisoning or self-injury with suicidal intent, that is not fatal

Completed Suicide: A suicide attempt resulting in death

Suicidal act: Refers to all suicides and suicidal attempts

Suicide: In the UK, suicide is defined as deaths given an underlying cause of intentional self-harm or injury/ poisoning of undetermined intent - see Suicide rates in the UK QMI - Office for National Statistics (ons.gov.uk) for detailed technical inclusions and exclusions

"Probable/Possible Suicide": An act of apparent self-harm resulting in a fatality which has not necessarily and may not receive a Coronial conclusion of suicide – included in the RTSS data set to aid operational review of local and regional deaths.

Suicidal ideation: Recurring thoughts or preoccupation with suicide

Self-harm: Self-harm is defined as an intentional act of self-poisoning or self-injury, self-harm does not include attempted suicide

Near Miss/No harm (Impact prevented) – Any self-harm incident that had a serious potential or likelihood to cause death by Suicide. Specific definition will vary on a case-by-case basis, as intentions and context as with the NHS National Reporting and Learning System[1] guidance on clinical care incidents and the MBRACE surveillance work [2]on maternal suicides

6 Glossary

Term	Definition
Real Time Suicide Surveillance	Real-time capture of (suspected) data, via Police-based data capture methods to generate the intelligence to inform suicide prevention activity
Postvention	Specialised Bereavement support and aftercare following a suicide focused on addressing the impact of traumatic bereavement
OHID	Office for Health Improvement and Disparities
ONS	Office for National Statistics
DHSC	Department of Health and Social Care
Age-specific mortality rate	The total number of deaths per 100,000 people of an age group
Age-standardised mortality rate	A weighted average of the age-specific mortality rates per 100,000 people and standardised to the 2013 European Standard Population. Age-standardisation allows for differences in the age structure of different populations and therefore allow valid comparisons to be made between geographic areas, the sexes, and over time.
Registration delay	The difference between the date which a death occurred and the date which a death was registered.
Statistical significance	The term "significant" refers to statistically significant changes or differences based on unrounded figures. Significance has been determined using the 95% confidence intervals, where instances of non-overlapping confidence intervals between figures indicate the difference is unlikely to have arisen from random fluctuation.
Years of life lost	Years of life lost is a measure of premature mortality and gives an estimate of the length of time a person would have lived had they not died prematurely. It can be used to compare the premature mortality experience of different

[1] Severity Mapping and Examples (england.nhs.uk)
[2] Near-Miss Suicide in Pregnancy | UKOSS | NPEU (ox.ac.uk)

	populations and quantify the impact on society from suicide.
TVP	Thames Valley Police
NCISH	National Confidential Inquiry into Suicide and Safety in Mental Health

7 Executive summary

The Pan Berkshire Strategy has been redrafted – building on the previous strategy and draft recommendations developed in 2021 (see appendix B - to capture system changes and the evolution of the National Suicide Prevention Agenda.

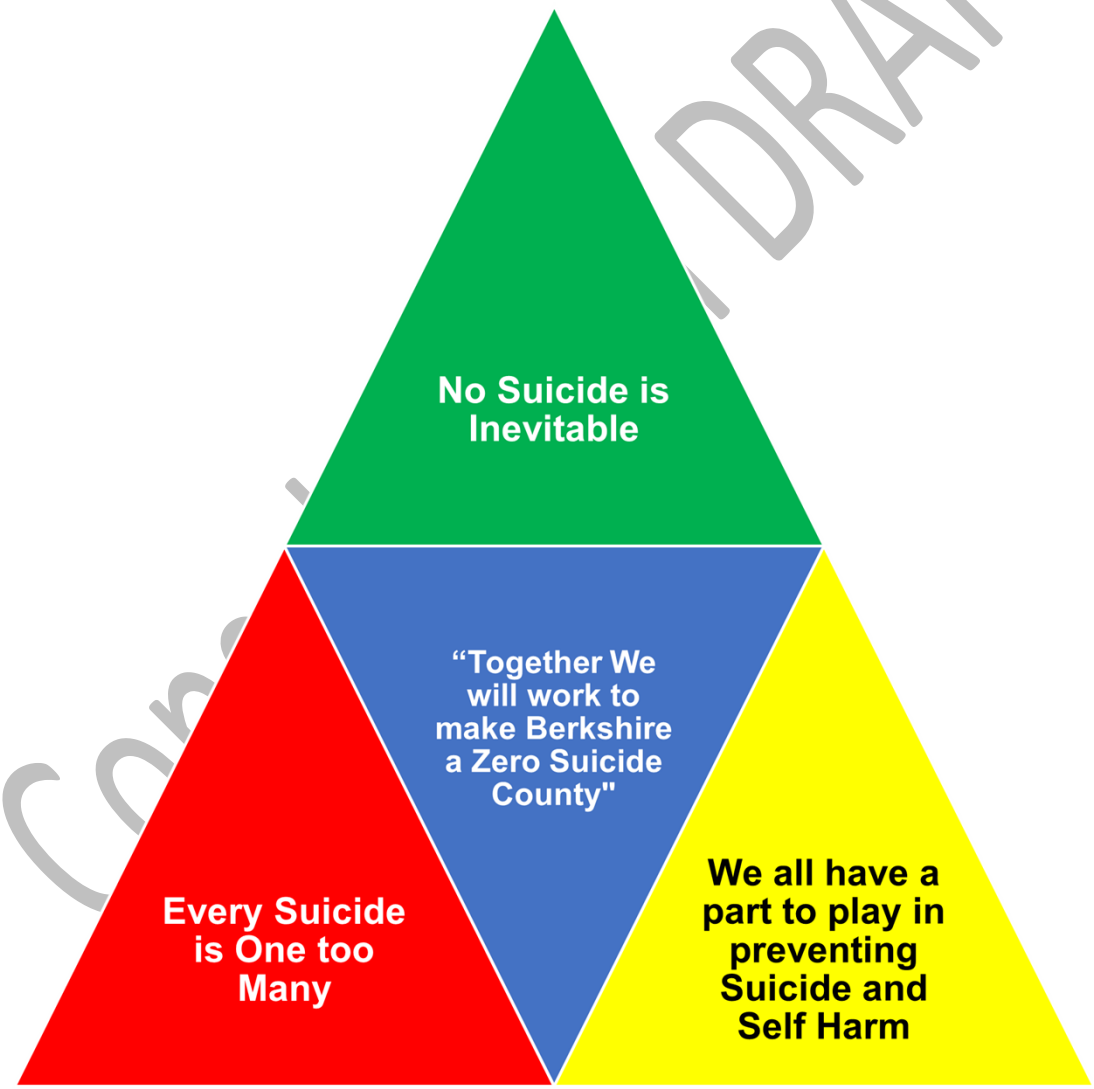

Fig 1 The Vision and Key Principles for the Pan Berkshire Strategy

This Consultation draft of the Pan Berkshire Suicide Prevention Partnership seeks your views on the next steps for the Pan Berkshire Partnership and Strategy that

sets out the works we aim to deliver. The Strategy sets out a Vision for a Zero Suicide approach for the County, that supports works flowing from National level and informs delivery in Local areas.

With a simple Vision "*Together we will work to make Berkshire a Zero Suicide County*" and three key guiding principles "No Suicide is inevitable", "Every Single life lost to suicide is one too many" and "We all have a part to play in preventing Suicide and Self Harm", the Strategy aims to:

- Set out the context for Suicide prevention in Berkshire
- Propose a new draft structure for the Partnership that helps the support Vision
- Outline the need to balance Suicide prevention works between County Wide and Local levels

The National Suicide Prevention Strategy Self Harm in 2017 for Suicide Prevention for the UK sets out 7 core recommendations that form the foundation for the Pan Berkshire works. [3] Building upon these an initial ten-point plan outlines key development priorities for the Pan Berkshire system. These - along with the national priorities suggest a range of local development priorities.

Alongside this the Strategy reflects on the need to address the three key areas for local development set out in the PHE Practice and Local Area resource[4]

1. **Establishing a multi-agency suicide prevention group involving all key statutory agencies and voluntary organisations**
2. **Completing a suicide audit**
3. **Developing a suicide prevention strategy and/or action plan that is based on the national strategy and the local data**

Together they frame responses at three levels and with the Recommendations framed in earlier Strategic drafts will be used to develop a comprehensive five-year Workplan.

National Strategic Priorities	1. Reduce the risk of suicide in key high-risk groups 2. Tailor approaches to improve mental health in specific groups 3. Reduce access to the 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 7. Reduce rates of self-harm as a key indicator of suicide risk
Pan Berkshire Development Priorities	1 Introduce suicide prevention across all policy (areas) 2. Improve methods to tackle root cause vulnerability 3. Establish a trauma informed approach 4. Assess and strengthen ways of tackling inequalities

[3] Preventing suicide in England: Third progress report (publishing.service.gov.uk)
[4] PHE_LA_Guidance_25_Nov.pdf (publishing.service.gov.uk)

	5. Establish a focus on debt and cost of living 6. Improve focus on children and young people 7. Establish means to address female suicide rates 8. Strengthen focus on links between mental health, self-harm and suicide 9. Continue to develop and establish support for people bereaved by suicide 10. Develop means for family support to ensure individual wellbeing
Local Suicide Prevention Action planning. **Suggested actions for Local refresh or development.**	1. Refresh of Local Action Plans and priorities 2. Upskilling of the workforce and community 3. Communication and engagement to share Zero Suicide Alliance and other key resources and concepts 4. Data and local insight works in support of the local and pan Berkshire RTSS and intelligence works 5. Identification of a named Strategic level SP lead to ensure delivery with local Systems and Portfolio Holders 6. Continue to support local data intelligence and analysis works (RTSS and review processes)

Table 1 The National, Regional and Local Suicide Prevention Action Planning

The Workplan will - **subject to consultation** - initially focus on a new audit and needs assessment and building the new partnership structure and the supportive offers at pan Berkshire level as set out above and below. Alongside this the Partnership structure will be established and Terms of Reference generated to agree the scope and remit of the groups and partnership and the level of support required for Local Areas.

The Workplan will also address – subject to the feedback received in the consultation - potential Regional or Local area responses to the Prevention Concordat for Better Mental Health and or a specific suicide prevention orientated pledge for either Berkshire wide or local areas to engage with.

National, Regional and Local works point towards several key groups who will be priorities for both County wide and Local works. Suicide Prevention **works must meet the needs of the whole community (Universal Proportionalism)**[5] but there are groups or cohorts that require additional or specialised focus.

This consultation Draft, with its revised approach to the partnership and Local area support and a refreshed Workplan which will be informed by the consultation - are direct responses to National, Regional and Local needs.

We hope you will engage with this draft and help us to refine agree and deliver it.

8 Forward to the Refreshed Strategy

[5] Marmot Review report – 'Fair Society, Healthy Lives | Local Government Association

In 2021, 102, 472 Self Harm admissions were recorded in England[6], a rate of 181.2 people per 100,000. In 2021, there were 5,583 suicides registered in England and Wales, equivalent to a rate of 10.7 deaths per 100,000 people[7]. In the same year 63 people died though suicide in Berkshire.

Each of these admissions is a person in need of our support, each of these deaths is an individual tragedy.

Together they are a call to collective action for us all.

Prevention of suicide and support for those who self-harm is both a moral imperative and national, regional and local priority. The multi-agency Berkshire Suicide Prevention Partnership has been working to address a wide range of actions to improve the responsiveness and impact of the support we offer to those who self-harm and drive the prevention of suicides and improve the support available to those impacted by suicide related bereavement. This refreshed strategy has been drafted to reflect significant changes across the health and social care landscape, and to support and build upon the wide range of works that are underway across the county, the wider Southeast Region and the UK.

No suicide is inevitable, and we are clear that we are aiming for Zero Suicides in Berkshire, whilst acknowledging that we may not currently be able to prevent all deaths from suicides now.

We need to do much more to ensure our prevention actions are as effective and aligned as we can make them, and where deaths occur, that we learn everything we can from them, to help us refine and develop more effective preventative actions.

This ambition and this candour are the two key drivers to the Pan Berkshire Strategy which aims to provide a route map and pragmatic approach to balancing and supporting the works that support Suicide Prevention from National, Regional, and Local – and Individual levels.

We aim to work together with a wide range of partners to implement this strategy and the local action planning it supports to help each partner in the Berkshire system help reduce the risk of suicide occurring.

With a wide range of works from raising awareness of suicide prevention amongst the public, as well as training for people in a range of voluntary and professional roles, to system wide support for data sharing, intelligence led analysis of trends and learning from local and national works we aim to equip the Berkshire system and the communities we serve to recognise when someone is struggling and to know what to do next.

[6] Suicide Prevention Profile - OHID (phe.org.uk)
[7] Suicides in England and Wales - Office for National Statistics (ons.gov.uk)

By initiating conversation, enhancing awareness, providing support, and directing help to those who need it, we can reach out to support those who are self-harming, and we can all help prevent suicides and help save lives.

There is always much more we can all do. Join us in Making the Vision for Berkshire as a Zero Suicide County a reality.

Professor Tracy Daszkiewicz
Director of Public Health West Berkshire

Stuart Lines
Director of Public Health East Berkshire

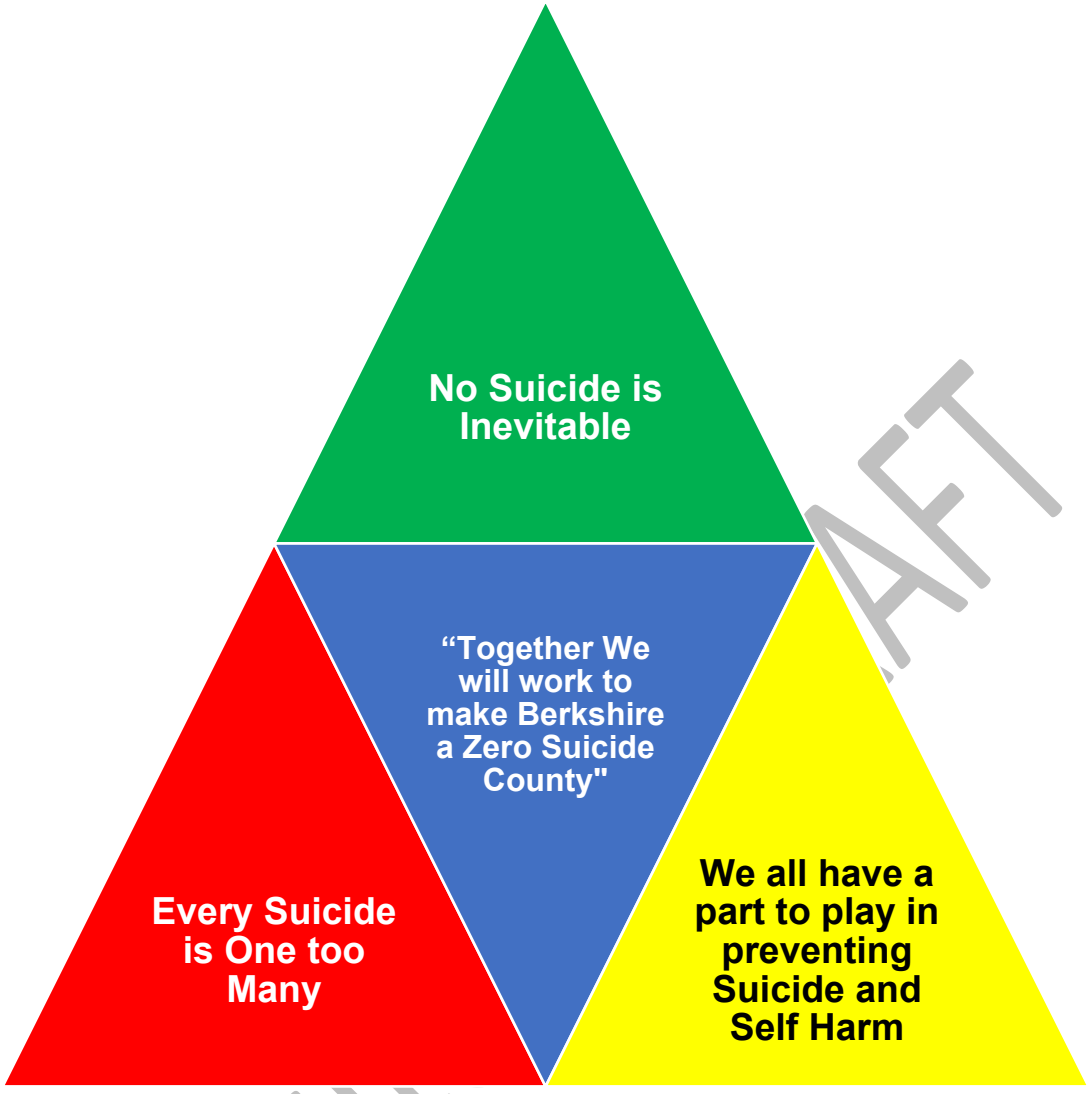

Fig 2 The Vision and Key Principles for the pan Berkshire Suicide Prevention Strategy

9 The Vision for Suicide Prevention in Berkshire

Our Vision is simple and draws from the World Health Organisation Preventing Suicide: A Global Imperative[8], the National Suicide Prevention Strategy[9] and the local works across the six Berkshire Local Authorities and the two NHS integrated Care Systems.

There are seven priority areas for action recommended by the national suicide prevention strategy and subsequent progress reports as follows:

"Together we will work to make Berkshire a Zero Suicide County - We will use our resources in partnership to tackle the issues that drive suicide and provide the right support at the right time and right place to prevent it."

This Vision is based upon three key principles and the call to action they inspire:

No Suicide is inevitable.	We must do all we can to prevent them, and where we cannot, to learn everything we can to help us refine and strengthen the systems and works we must prevent further deaths by suicide and provide better and earlier support for people who Self Harm across all age ranges and groups of people.
Every single life lost to suicide is one too many.	Suicide prevention works. Support for those who Self harm works. We can prevent suicides if we act together, and the time to do that is now. We all need to understand that suicide prevention - and the linked agenda of Self Harm - is everyone's business - we all have a role in preventing suicide and we need to provide culturally competent and early support and intervention for all age groups and all communities.
We all have a part to play in preventing Suicide and Self Harm	As professionals, as members of the community, as part of a system or a team, or as individuals. We are human and our shared humanity gives us the duty to help, and we will together share the tools, insights, training and experiences that help us drive suicide prevention and support those who Self Harm.

We know that the reasons why an individual may choose to take their own life are extremely complex and that there is a very broad range of risk factors and vulnerabilities that need to be addressed to prevent suicide.

We know that preventing suicides continues to be extremely challenging and it will take years and the collective efforts of all to achieve our ambition of Zero Suicides.

This strategy and action plan, and the works and strategies that precede it, represent important steps towards meeting this challenge for Berkshire as a County.

[8] Preventing suicide: A global imperative (who.int)
[9] Suicide prevention strategy for England - GOV.UK (www.gov.uk)

10 Towards Zero Suicide -

We know that we may not currently be able to prevent all suicides, and equally we refuse to accept that any death by suicide is effectively bound to occur, or in some way a "fact of life" predestined or inevitable.

Taking inspiration from the Zero Suicide Alliance[10](ZSA), we aim to deliver a "Zero Suicide" Approach to Berkshire.

The ZSA has four main areas of work in service of its foundational principle that ***Suicide is Preventable***

1. **Empowering all people to take positive action against suicide.**
2. **Learning from each other and sharing best practice for suicide prevention.**
3. **Using and advocating for data and research as a fundamental foundation to drive real change.**
4. **Promoting positive change as part of national standards and clinical guidelines.**

We take inspiration from these and echo the ZSA as we work towards the Zero Suicide challenge in Berkshire.

11 A Partnership Approach to Suicide Prevention

No single organisation can deliver effective suicide prevention in isolation. Effective sustainable SP flows from the combined knowledge, expertise and resources of organisations across the public, private and voluntary sectors.

All are essential to achieving Berkshire's Vision of a Zero Suicide County.

The Partnership Approach operates at three levels – each equal in as important as the others which together will support each other - and reflect the three levels of intervention from the Policy through to the Strategic and operational delivery areas.

Partnership Level	Key Activities
National	We will work with Regional and National Organisations including DHSC, OHID, NHSE, NCISH, NSPA, ZSA, National Charities, ADPH,
Regional	We intend to work with Neighbouring Counties and Systems – including the six Berkshire Local authorities, the two Integrated Care Boards, Thames Valley Police, SCAS and County Councils, Acute and Foundation Trusts and Anchor Institutions, Companies VCS and

[10] Welcome to the Zero Suicide Alliance (ZSA)

	large-scale Organisations to ensure we are supporting all partners in Berkshire to prevent suicides.
Local Area/Place	We intend to support local areas in Berkshire to refresh their local suicide prevention networks as they revisit and revise their local action plans so that they can drive suicide prevention across the Six Local Authorities. Building on local works and sharing and showcasing exemplary practice we aim to ensure that the local areas are supported with insight and resources that meet the needs of their local populations and plans and help us all contribute towards the overarching Vision for Berkshire.

12 Who are we?

The Pan Berkshire suicide Prevention Partnership is comprised of a wide range of statutory and Voluntary and community sector organisations. Some are strategic local or regional contributors to the agenda, others are specialists in the Suicide Prevention or postvention and bereavement support agenda, others involved as an aspect of their operational day to day delivery.

With a range of large and small organisations and subject matter specialisms the Partnership is a dynamic and essential way in which partners can focus attention on the many different aspects of the SP and related agendas.

12.1 The Proposed Restructured Partnership

Currently the Partnership is served by one subgroup – that effectively and creatively led on the insight works surrounding the links between the Domestic Violence Agenda and the wider partnership.

It is proposed that a revised structure for the Partnership – with revised Terms of Reference is established to ensure the Partnership is reporting into local system governance and assurance structures, such as the Health and Wellbeing Boards in each local authority and the wider Mental health partnerships that exist at local and NHS ICB footprints.

The revised structure will support both local and county wide delivery of refreshed and new resources and provide - based on the experience of the previous subgroup – a welcome refocussing of the wider partnership and greater accountability and assurance for local areas that their needs are being heard, understood and actioned by the different new structures.

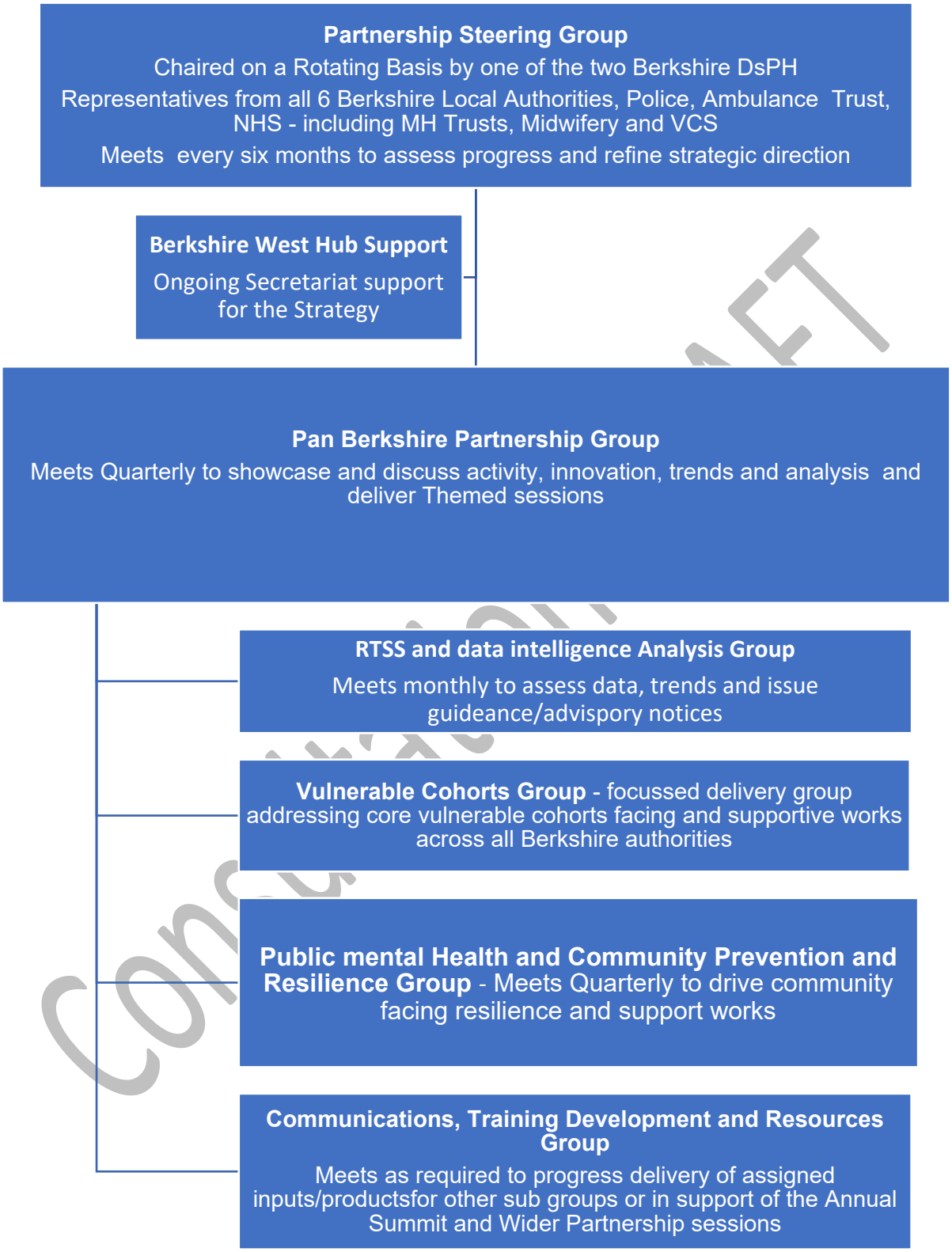

Fig 3 Proposed restructured Pan Berkshire Partnership

The proposed refresh of the strategy aims to ensure a balance between pan Berkshire system engagement and support for both county wide and local delivery.

In summary the proposed restructure establishes a core Strategic Steering Group and several delivery groups in support of the wider Pan Berkshire Partnership's aims and priorities.

Group	Core functions
Partnership Steering Group	Strategic Direction setting and shared leadership for the agenda across the County to support the Wider Partnership with reporting feed into each local Health and Wellbeing Board and NHS integrated Care Systems
Pan Berkshire Partnership Group	Main Partnership Body for discussion and sharing of insights activity and resources
Berkshire West Hub Support	Ongoing Partnership Secretariat support
RTSS and data intelligence Analysis Group	Key data intelligence, analysis and insights group aiming to support RTSS roll out and outputs with the wider system.
Vulnerable Cohorts Group	Delivery Group leading on key vulnerable cohorts of all ages identified at national and local level including but not limited to: People who are especially vulnerable due to social and economic circumstances; victims and perpetrators of Domestic Violence, Black, Asian and minority ethnic groups and migrants; lesbian, gay, bisexual and transgender people; and people who misuse drugs or alcohol, people with complex bereavement issues, neurodiverse people
Public Mental Health and Community Prevention and Resilience Group	Drive the sharing and take up of Public facing Mental health messages and seeks to support local areas by sharing core resources, best practice for the County wide and local prevention, resilience and support agendas
Communications, Training Development and Resources Group	The core operational/technical support group for other working groups to ensure that the Partnership can deliver high quality system inputs at a scale and frequency required to deliver sustainable progress towards a Zero Suicide County.

Fig 4 Pan Berkshire Suicide Prevention Partnership Groups and outline of functions

12.2 A Matrix Approach to Suicide Prevention

Overall, the Pan Berkshire Partnership will be adopting a Matrix approach to prevention as se out below in Figure 5.

Theme	Suicide Prevention (SP) across all policy areas	Tackling root cause Vulnerability	Trauma Informed	Tackling inequality	Mental Health	Think Family
Prevention	Evaluate suicide prevention strategies and opportunities to build SP into aligned policy areas	Understanding triggers, such as relationship breakdown, loss of job, economic insecurity, debt, addiction	Explore the life of a person, not just presenting behaviours and current situation	Understand the factors impacting groups who are disproportio nately affected by suicide.	Explore the foundations of good mental health and how to build resilience from the Early Years through Adulthood into Old Age	Understand and support services and the communities they serve to better comprehend the challenges and assets of the families and communities they serve
Awareness & Training	Translate the Government suicide prevention strategy into a training package	Indicators of risk understood by front line services	Think adverse childhood experiences, intimate partner violence, community violence	Understand and tackle systemic and unconscious bias and inequity and how it impacts on different communities	Families' opinion sought in mental health assessment and where at discharge into the community	Use family as the 24hr surveillance system to triangulate the wellbeing of the person at risk
Collaboration	Work with partners to advance a public health approach to suicide prevention	Improve understanding of the risk and protective factors of vulnerable populations	Work in partnership to deliver multiagency and multidisciplinar y personalised support for care	Innovate culturally relevant prevention strategies at a community level to prevent suicide	Capture the voice of people of all ages with experience of mental health to coproduce service offers and use community insight to drive change	Ensure that communities can access support and information about how they at community, family and individual levels can contribute towards the SP agenda and know how to access Crisis support when they need it
Evidence	Enhance the use of data sources and systems i.e., RTSS Have a Suicide needs assessment as part of the JSNA	Understand the key protective factors that lower the likelihood of suicide	Understand the role of past trauma that increase suicide, including childhood trauma links to adult suicide.	Identify evidence, or develop new approaches to build the evidence base that will contribute to tackling inequality in mental health and wellbeing and SP	Understand the factors that protect people experiencing suicidal ideation	Validity and utility of experiential evidence and non-traditional data sources to track and monitor risk and inform interventions

Fig 5 A Matrix Approach to Suicide Prevention (Daszkiewicz 2022)

13 Six Myths

The World Health Organization publication "Preventing suicide: A global imperative"[11] outlines six core myths and the surrounding the Suicide Prevention agenda, which we will need to address with the public and professional communities we work with and for.

No.	Myth	Fact
1	**MYTH:** People who talk about suicide do not intend to do it.	**FACT:** People who talk about suicide may be reaching out for help or support. A significant number of people contemplating suicide are experiencing anxiety, depression and hopelessness and may feel that there is no other option.
2	**MYTH:** Most suicides happen suddenly without warning.	**FACT:** The majority of suicides have been preceded by warning signs, whether verbal or behavioural. Of course, there are some suicides that occur without warning. But it is important to understand what the warning signs are and how to look out for them.
3	**MYTH:** Someone who is suicidal is determined to die.	**FACT:** On the contrary, suicidal people are often ambivalent about living or dying. Someone may act impulsively by drinking pesticides, for instance, and die a few days later, even though they would have liked to live on. Access to emotional support at the right time can prevent suicide.
4	**MYTH:** Once someone is suicidal, he or she will always remain suicidal.	**FACT:** Heightened suicide risk is often short-term and situation specific. While suicidal thoughts may return, they are not permanent and an individual with previously suicidal thoughts and attempts can go on to live a long life.
5	**MYTH:** Only people with mental disorders are suicidal.	**FACT:** Suicidal behaviour indicates deep unhappiness but not necessarily mental disorder. Many people living with mental disorders are not affected by suicidal behaviour, and not all people who take their own lives have a mental disorder.
6	**MYTH:** Talking about suicide is a bad idea and can be interpreted as encouragement.	**FACT:** Given the widespread stigma around suicide, most people who are contemplating suicide do not know who to speak to. Rather than encouraging suicidal behaviour, talking openly can give an individual other options or the time to rethink his/her decision, thereby preventing suicide.

[11] ibid

14 The Context for the Suicide Prevention Strategy in Berkshire

14.1 Balancing the Strategy

There is an obvious need to ensure that this Strategy links into the National and local area agendas. The Strategy requires nuanced, patient and collaborative work to get the balance right between the National, Regional and Local –we will not be able to proceed with and effective partnership and face the challenge of our Vision.

Some of these works - might be best served by County wide delivery, whilst other areas arising from local circumstances – such as action planning reflecting local distinctiveness, local responsibilities and leadership is an obvious local requirement.

Key to this will be the revision of the Terms of Reference and structures that support the Partnership, its local sign off and overarching governance and assurance processes.

This revision aims to support the way the Partnership will work with a wide range of local and regional governance structures, including health and Wellbeing Boards, Local Mental Health systems governance and both statutory and VCS and community groups. Above all the Partnership will continue to champion and share the challenges and achievements of all Berkshire Partnership members.

14.2 The Health and Social Care Act 2022 and Berkshire Oxfordshire & Buckinghamshire and Frimley Integrated Care and Systems.

With significant developments arising from the act, and the formation of the Berkshire Oxfordshire and Buckinghamshire Integrated Care Strategy and Board there is a significant reorganisation of regional and local Place based delivery across health services across all age ranges. A range of materials for public and professional consultation on the overall strategy for delivery of services across the BOB footprint is currently being drafted, with the intention that “Engagement” versions of its key agendas and priorities for provision of services across the Starting Well, Living Well and Ageing Well agendas is shred before between November and December 2022. Public Health officers from across the Berkshire System have been heavily involved in the drafting of these and have provided steer and insight on the centrality of SP as a priority area for works within the border context of physical and mental health services. Similarly works are underway in Berkshire East to establish the Frimley ICS and ensure that priority agendas including Mental health and Wellbeing – including Suicide Prevention - are addressed at ICS and place-based levels.

The cross-border nature of the SP agenda[12] – where vulnerable people have contacts and associations or presentations across local geographical and service delivery borders – has been stressed alongside the need to ensure that there is a range of local place-based support for priority agendas including SP and “post-vention” support and widened availability of

[12] See NIMH » Suicide Prevention (nih.gov) and Regional suicide prevention planning: a dynamic simulation modelling analysis | BJPsych Open | Cambridge Core

wellbeing and social prescribing style supports for local places, communities and individuals requiring additional support to mitigate the impacts of the national economic situation.

14.3 Impact of COVID-19

The COVID-19 pandemic has exacerbated inequalities including those that impact on suicide risk and has presented new challenges for different groups of the population[13], therefore monitoring impact and taking early action is essential.

The COVID-19 Mental Health and Wellbeing Recovery Action Plan sets out a broad plan covering 2021 to 2022 in response to the mental health impacts of the pandemic, which will form the foundation for future policy development and delivery as knowledge and understanding of the impacts of the pandemic as it grows. Actions and commitments within the plan aim to support people at risk of self-harm or suicide. This includes supporting the population to act and look after their mental wellbeing, preventing the onset of mental health difficulties and supporting specialist services to continue to expand and transform to meet needs[14].

The National Confidential Enquiry into Suicide and Safety in Mental Health (NCISH) [15] is the Manchester University SP surveillance and prevention "observatory" commissioned by the NHS via the Healthcare Quality Improvement Partnership.[16] They and the National Suicide Prevention Alliance have published a wide range of materials reports and analyses of how the Covid 19 Pandemic have impacted on both the numbers and rate of completed suicides in the UK and Global system.[17] In summary they report that whilst there may have been local increased in numbers there has not – thankfully – been an increase in the overall UK rate [18], refuting a wide range of media reported increases on rates and or numbers of completed suicide over both. The NCISH Lancet report goes on to note "*These are early findings:…It is too soon to examine the effect of any economic downturn - serious economic stresses as a consequence of COVID-19 may represent the greatest risk of a rise in the suicide rate. These overall figures may mask increases in suicide in population groups or geographical areas, just as the impact of the acute pandemic has not been uniform across communities"*[19].

Given the current and emerging economic context it is important to note the NCISH recommendations for additional support for those whose mental health will be

[13] One year on: How the coronavirus pandemic has affected wellbeing and suicidality. Samaritans (2021). Available Samaritans_Covid_1YearOn_Report_2021.pdf Last accessed 17/08/21
[14] COVID-19 mental health and wellbeing recovery action plan Our plan to prevent, mitigate and respond to the mental health impacts of the pandemic during 2021 to 2022. HM Government (2021). Available COVID-19 mental health and wellbeing recovery action plan (publishing.service.gov.uk) Last accessed 17/08/21
[15] NCISH | The University of Manchester
[16] HQIP – Healthcare Quality Improvement Partnership
[17] See NCISH | National academic response to COVID-19-related suicide prevention - NCISH (manchester.ac.uk) and Suicide in England in the COVID-19 pandemic: Early observational data from real time surveillance - The Lancet Regional Health – Europe
[18] Essentially rate is the number of deaths per 100k of population in any given area for a set period of time.
[19] NICISH Lancet ibid.– see Discussion

adversely impacted by the economic turbulence and disruptions faced nationally, regionally and locally. It is hoped but not by any means certain that HM Treasury will announce the raft of supports for services, communities and individuals to help mitigate the impacts of the national economic position on individuals.

14.4 The Cost-of-Living Crisis

With the UK economy undergoing considerable turbulence and economic circumstances having an obvious and well understood impact on the mental health and wellbeing of the population the ONS has published a helpful but challenging summary of the economic impacts on adult depression. The summary [20]notes

"Around 1 in 6 (16%) adults experienced moderate to severe depressive symptoms; this is similar to rates found in summer 2021 (17%), however higher than pre-pandemic levels (10%) ….

…When comparing within population groups, prevalence of moderate to severe depressive symptoms was higher among adults who were economically inactive because of long-term sickness (59%), unpaid carers for 35 or more hours a week (37%), disabled adults (35%), adults in the most deprived areas of England (25%), young adults aged 16 to 29 years (28%) and women (19%)….Around 1 in 4 (24%) of those who reported difficulty paying their energy bills experienced moderate to severe depressive symptoms, which is nearly three times higher than those who found it easy to pay their energy bills (9%)….Around 1 in 4 (27%) adults who reported difficulty in affording their rent or mortgage payments had moderate to severe depressive symptoms; this is around two times higher compared with those who reported that it was easy (15%)…Nearly a third (32%) of those experiencing moderate to severe depressive symptoms reported that they had to borrow more money or use more credit than usual in the last month compared with a year ago; this is higher compared with around 1 in 6 (18%) of those with no or mild depressive symptoms."

This echoes the insights flowing from NICISH and others on the characteristics and risk factors of people who Self Harm or attempt and sadly complete Suicide.

14.5 The National Picture

England's overarching mental health strategy 'No Health without Mental Health' (HM Gov 2011)[21] references suicide throughout as a key indicator of mental ill-health and stated that suicide prevention can only be achieved by improving mental health across the whole population. It heralded the 2012 whole Government Suicide Prevention Strategy[22], the first UK Suicide Prevention Strategy. Since 2012 the

[20] Cost of living and depression in adults, Great Britain - Office for National Statistics (ons.gov.uk)
[21] No Health Without Mental Health: a cross-government outcomes strategy - GOV.UK (www.gov.uk)
[22] Ibid and Preventing suicide in England: Fifth progress report of the cross-government outcomes strategy to save lives (publishing.service.gov.uk)

Strategy has been refreshed via a series of annual reports and updates reflecting the progress made against the overall commitment of reducing the overall suicide rate by 10% by 2020.

The National Strategy initially set out 6 and since then a refined list of 7 priorities – including Self Harm in 2017 for Suicide Prevention for the UK. These 7 Priorities are the foundations of all works we are aiming to deliver both at Regional and local level.[23]

1. **Reduce the risk of suicide in key high-risk groups**
2. **Tailor approaches to improve mental health in specific groups**
3. **Reduce access to the 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**
7. **Reduce rates of self-harm as a key indicator of suicide risk**

These 7 areas were supplemented by a Public Health England[24] guide to Local Suicide prevention Planning that recommends short term actions with a co-ordinated whole systems approach for local plans, alongside the seven priority areas of the national strategy in the long-term.

In the Five Year Forward View for Mental Health[25] the Independent Mental Health Taskforce set a national ambition to reduce the suicide rate in England by 10 per cent by 2020/21. Recommendations were made for local government to contribute to the above ambition by putting in place a multi-agency suicide prevention plan by 2017. The plan should set out targeted actions in line with the National Strategy and demonstrate how evidence-based interventions that target high-risk locations and high-risk groups can be implemented, drawing on localised, real-time data. In partnership with the National Suicide Prevention Alliance[26], Public Health England published and refined a guidance and support manual for local suicide prevention planning in October 2016[27] and a revised version was made available in 2020[28]

The guidance focuses on three main recommendations that were first highlighted by the All-Party Parliamentary Group on Suicide and Self-harm Prevention as essential to successful local implementation of the national strategy. These were:

[23] Preventing suicide in England: Third progress report (publishing.service.gov.uk)
[24] PHE became the Office for Health Improvement and health Disparities in 2021
[25] NHS England » The Five Year Forward View for Mental Health
[26] About Us - NSPA
[27] Suicide prevention: developing a local action plan - GOV.UK (www.gov.uk)
[28] Local Suicide Prevention Planning: A Practical Resource. PHE (2020) Available PHE_LA_Guidance_25_Nov.pdf (publishing.service.gov.uk)

4. **Establishing a multi-agency suicide prevention group involving all key statutory agencies and voluntary organisations**
5. **Completing a suicide audit**
6. **Developing a suicide prevention strategy and/or action plan that is based on the national strategy and the local data**

National, Regional and local Suicide Prevention is underpinned by **the Consensus Statement on Data Sharing**[29] which underpins the Real Time Suicide Surveillance System and other multi-agency arrangements for suicide prevention and analysis.

The report recommends that tackling inequalities remains a priority, areas should continue to understand the specific needs for different groups, monitor demands for mental health providers and engage with the voluntary and community sector. Plans must also address the specific needs of the populations they cover.

A revised National Suicide Prevention Strategy[30] is scheduled for release in 2023, with an enhanced focus expected on priority agendas including: Ethnicity, Online Harms, Economic Stresses, Pre Covid trends in CYP, the impact of the Pandemic, Data collection, analysis and intelligence, Domestic Violence, Gambling and the experiences of LGBTQ people.

14.6 Changes to NICE Guidance on Self Harm

Self-harm covers a wide range of behaviours that can cause injury or harm in some way, including isolated and repeated events.

Every episode of self-harm is different, and people will experience it in different ways. Whatever method is used, the underlying feelings and distress underlying the behaviour must be taken seriously.

Self-harm and suicide attempts can also be detrimental to an individual's long-term physical health for example, paracetamol poisoning is a major cause of acute liver failure. Overdosing is extremely dangerous as it is difficult to predict how your body will cope and can be impossible to reverse. Self-cutting can result in permanent damage to tendons and nerves. Many actions to prevent and reduce suicide will have physical health benefits for those who self-harm.

Self-harm is an important public health issue and often people keep self-harm a secret because of shame or fear of it being seen or being labelled or judged. They may cover up their skin in order to avoid discussing the problem. Sometimes there are psychological scars that are difficult to cope with, often unseen by others. Self-harm is not typically an attempt at suicide, but self-harm is an important risk factor for suicide.

Establishing an accurate prevalence of self-harm is difficult to precisely determine. This is because there is a "hidden" population of young people who self-harm in the community but do not present to local services for treatment. This is illustrated in the Iceberg model of self-

[29] https://www.gov.uk/government/publications/consensus-statement-for-information-sharing-and-suicide-prevention/information-sharing-and-suicide-prevention-consensus-statement

[30] Reported by Prof. Louis Appleby NCISH (@NCISH_UK) / Twitter

harm, in that for every young person that presents to hospital for self-harm there are at least 10 further individuals who do not present at hospital for self-harm. At the tip of the iceberg are suicides, which are highly visible, beneath are higher rates of hospital-treated self-harm and at the base are very common but hidden self-harm (Hawton, 2019).

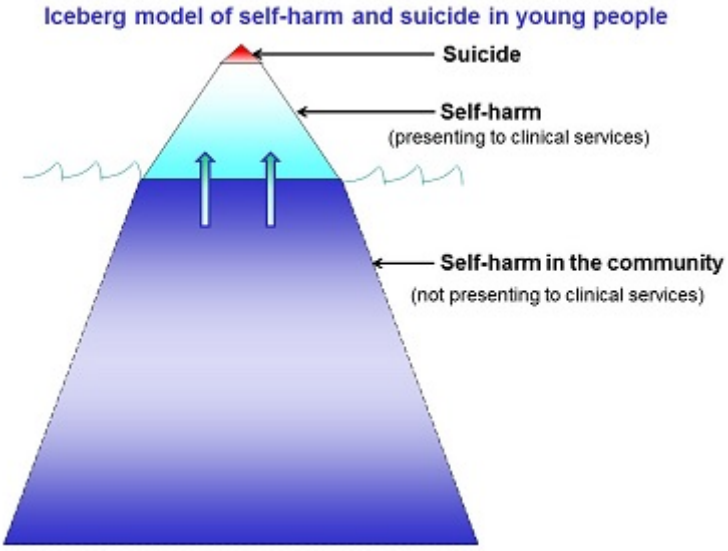

Figure x: Iceberg model of self-harm and suicide in young people (University of Oxford, 2019)

Those who repeat self-harm are at significantly greater risk of completing suicide than those who have a single episode. It can be difficult to differentiate behaviours where there is an intent to die (e.g., cutting with suicidal intent) from those where there is a pattern of self-harm with no suicidal intent (e.g., habitual self-cutting). Any intentional harm to the body counts as self-harm. 'Minor' self-harm can lead to progressively become more serious or frequent. Sometimes people harm themselves in ways that are dangerous, and they might accidently kill themselves (e.g., cutting too deep on certain parts of the body or overdosing). Young people may lack judgement about the level of self-harm they have applied, and this could lead to irreversible harm or accidental death.

The Berkshire Suicide Audit found that 21% of people who died by suicide had a history of self-harm, and previous self-harm is flagged in local RTSS data as a feature in the relevant medical history of those who have died.

For these reasons, it is important to address concerns around self-harm early, support people to find alternatives and distractions to self-harm and identify what triggers self-harm. People who self-harm can also be supported to stay safe if they do self-harm (e.g., having a self-harm first aid kit available and pain relief, avoiding certain parts of the body etc) as well as when to avoid self-harming (e.g., when tired, or under the influence of alcohol). It might not be possible for someone who self-harms to stop doing so immediately, but they should be encouraged to get help.

People self-harm for a range of reasons, for some it is a way of coping with difficult or distressing feelings, but research has shown that long term self-harm does not help to reduce that distress. Although the data shows that the majority of self-harm occurs among people aged under 18 and is strongly associated with puberty, especially in girls, self-harm can affect people of any age, social status gender identity, sexuality, race or culture. People who self-harm may have a diagnosable mental health condition, or they may have none.

Self-harm is one of the top five causes of acute hospital admissions in the UK (PHE, 2021). PHE state that those who self-harm have a 1 in 6 chance of repeat attendance at A&E within the year and one study showed a subsequent suicide rate of 0.7% in the first year which is 66 times the suicide rate in the general population[3]. This means that someone who has self-harmed is more likely to die by suicide compared to someone who has never self-harmed.

During 2019/20, there were 705 admissions of children and young people from Berkshire to hospital as a result of self-harm. Rates for each local authority since 2011/12 can be seen in the charts below. Rates of admission were significantly lower than the regional average for children and young people living in Slough, and Windsor and Maidenhead. Rates were higher than the national average but comparable to the regional average in Bracknell Forest and Wokingham. In Bracknell Forest, rates jumped from 2014/15 to 2015/16 and have risen again between 2018/19 and 2019/20. Rates in Wokingham, however, have continued to remain above the national average. Rates in Reading and West Berkshire show a similar pattern to each other, increasing up to a peak in 2016/17, prior to falling back in line with national and regional averages.

NHS England continues to work to ensure that every person who presents at an emergency department for self-harm receives a psychosocial assessment and is directed to appropriate support. And within South Central Ambulance Service (SCAS) a steering group is in place to evaluate training from an expert reference group to adapt and adopt content to different audiences, including universal clinician, social care and voluntary sector.

In September 2022 NICE published Nice Guidance 225 covering Self Harm across all ages.[31] This is a substantial and wide-reaching refresh of NICE guidance for the agenda and a major updating of clinical and social care facing standards for the care of people of all ages who self-harm. The guidance which covers assessment, management and prevention of recurrence for children, young people and adults who have self-harmed, aims to support the needs of a wide range of priority groups of vulnerable people. This includes those with a mental health problem, neurodevelopmental disorders or learning disabilities and applies to all sectors across the statutory and voluntary and community sector that work with people who have self-harmed. NG225 notes the wide range of vulnerable groups that need to be supported if we are to address self-harm including education, community and health and social care settings.NG225 is the first major update to the agenda for over a decade, stresses a number of key areas for action including the stress on psychosocial assessment as the key to successful support, the prohibition of mechanistic risk assessment as it has potentially fatal consequences and a restatement of the linkages and alignments needed with the suicide prevention agenda.

14.7 Suicide Rates in England and Wales

Suicide is a highly complex agenda area. The Office for National Statistics[32] define suicide as “a death with an underlying cause of intentional self-harm or an injury or

[31] Overview | Self-harm: assessment, management and preventing recurrence | Guidance | NICE
[32] Suicides in England and Wales - Office for National Statistics (ons.gov.uk)

poisoning of undetermined intent"[33]. The latest available ONS summary gives us the following headlines.[34]

- In 2021, there were 5,583 suicides registered in England and Wales, equivalent to a rate of 10.7 deaths per 100,000 people; while this was statistically significantly higher than the 2020 rate of 10.0 deaths per 100,000 people, it was consistent with the pre-coronavirus (COVID-19) pandemic rates in 2019 and 2018.
- The fall in the suicide rate in 2020 was likely to have been driven by a decrease in male suicides at the start of the coronavirus pandemic, and delays in death registrations because of the pandemic.
- The latest figures include deaths that occurred in 2020 and were subsequently registered in 2021 owing to disruption to coroners' inquests; this provides evidence that the suicide rate did not increase because of the coronavirus pandemic.
- Around three-quarters of suicides were males (4,129 deaths; 74.0%), consistent with long-term trends, and equivalent to 16.0 deaths per 100,000, the rate for females was 5.5 deaths per 100,000.
- Among females, the age-specific suicide rate was highest in those aged 45 to 49 years (7.8 deaths per 100,000), while among males it was highest in those aged 50 to 54 years (22.7 deaths per 100,000).
- Females aged 24 years or under have seen the largest increase in the suicide rate since ONS started to assess suicide rates in 1981.
- In 10 out of the 11 previous years, London has had the lowest suicide rate of any region of England (6.6 deaths per 100,000), while the highest rate was in the North East with 14.1 deaths per 100,000 in 2021 – with the South East region having 10.4 deaths per 1000, 000 per year

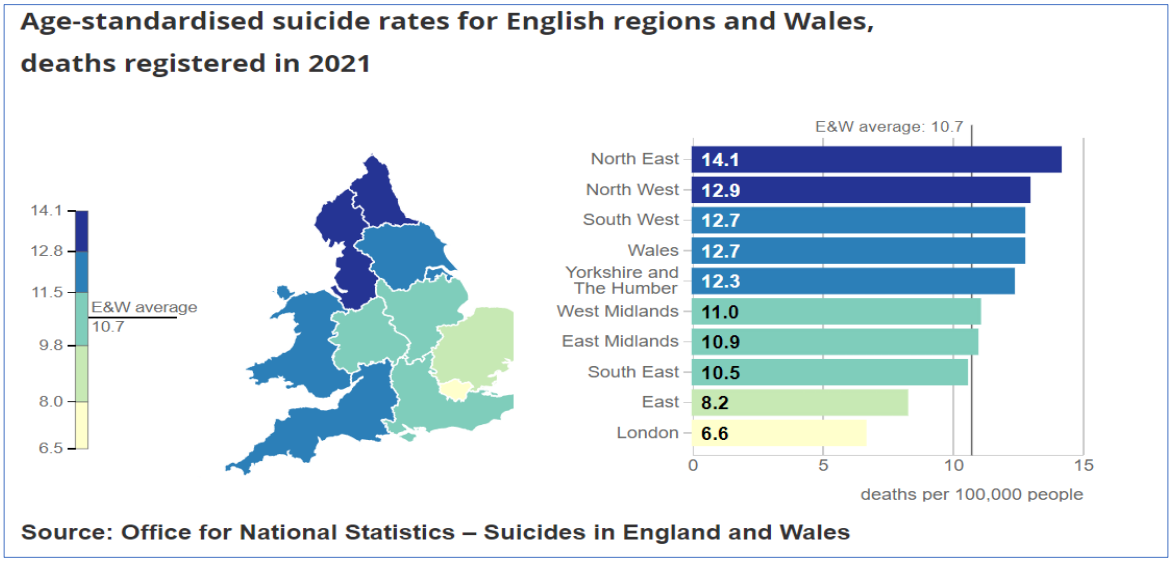

Fig x ONS analysis of the Suicide rate per 100, 000 by region 2022[35]

[33] See Suicide rates in the UK QMI - Office for National Statistics (ons.gov.uk) for more detail.
[34] Suicides in England and Wales - Office for National Statistics (ons.gov.uk)
[35] Suicides in England and Wales - Office for National Statistics (ons.gov.uk)

14.7 Coronial Inquests and Conclusions

Official statistics - because of the complexity of the agenda -under-report the actual number, and therefore rate, of suicide in most countries including the UK.

In England and Wales, all unnatural deaths which includes all suspected suicides are subject to a Coronial Inquest[36], which seeks to ascertain the cause of death. The death cannot be registered – and a cause of suicide recorded - until the coronial inquest is completed, which can in some cases take months and sometimes years. The average time for completion of an inquest in 2021, was 31 weeks.[37] These significant time lags between occurrence of a death and its registration as a suicide, figures mean that official statistics show suicides registered within a particular year, rather than deaths which occurred in that year.

The same data showed that in 2021 "32,300 inquest conclusions were recorded in total, up 4% on 2020. Accident/misadventure, suicide and unclassified conclusions had the largest increases, up 2%, 8% and 24% on 2020, to 7,700, 4,800 and 8,100 inquest conclusions in 2021 respectively".[38] From July 2018, the standard of proof used by coroners to determine whether a death was caused by suicide, changed. Previously, the "criminal standard" was applied, meaning that the coroner required evidence "beyond all reasonable doubt" that a death was caused by suicide and now only the "balance of probability" is required. The legal change has not resulted in any significant change in the reported suicide rate in England and Wales with recently observed increases in suicide among males and females in England, and females in Wales, beginning before the standard of proof was lowered.[39]

Misclassification of deaths is a key issue in the English and Welsh systems and the use of "narrative conclusions" and Open conclusions - where there is insufficient evidence to conclude that the death was a suicide or an accident -by coroners avoids the issue of trying to restrict conclusions to one single cause (or code). Deaths may often be coded as 'accidental' rather than 'suicide' or 'undetermined intent' by the ONS[40].

14.8 Real Time Suicide Surveillance

With the Real Time Suicide Surveillance system data on a broader level of "probable or possible suicides is included to ensure that there is a wider and more immediately available data set to help inform local prevention orientated actions across the County. It is crucial to note that not all cases covered by the RTSS. data set will go on to receive a Coronial conclusion of suicide

[36] Guide to coroner services - GOV.UK (www.gov.uk)
[37] Coroners statistics 2021: England and Wales - GOV.UK (www.gov.uk)
[38] Ibid.
[39] Change in the standard of proof used by coroners and the impact on suicide death registrations data in England and Wales - Office for National Statistics
[40] Narrative verdicts and their impact on mortality statistics in England and Wales - PubMed (nih.gov)

14.9 The Regional Picture

This strategy builds on the previous Berkshire Suicide Prevention Strategy (2017-2020) and the initial redraft of 2021 and serves as the stepping off point for the next five years where we take forward the key underlying principles and identify new priorities.

A key element of the Strategy reflects the development of Real Time Suicide Surveillance and the imperative to continually refresh the works we are delivering so that suicide prevention responses are tailored to meet the needs of emerging agendas flowing from trends identified in the data and that local ownership and championship of suicide prevention works and community awareness is enabled to flourish.

As we move through winter and with the context of the Covid 19 pandemic and the emerging economic turbulence it is essentially that we continually review and renew the works we deliver to prevent Suicide, and with this in mind there will be an annual refresh of the five year Pan Berkshire strategy to ensure it is supporting local area prevention of suicides alongside supporting the delivery of bereavement support and capturing all possible learning we can from those deaths that we are unable at this time to prevent.

14.10 Deaths by Suicide in Berkshire – an Overview from 2019 -2021/2022 and year to date from the RTSS data on “probable Suicides”.

Pan Berkshire

- In 2021 there was a total of 56 deaths by suicide in all of Berkshire, this was the lowest total for at least the last 5 years. Of these deaths 35 were male and 21 were female.
- So far in 2022 there have been 58 deaths across Berkshire.
- Of these deaths 43 were males and 15 were females.

Deaths by age in Berkshire:

In 2022 most deaths can be seen in the 30 to 39 age bracket (15), followed by 20-29 (11) and 60-69 (10). There have sadly been several deaths by suicide in those under 20.

There is some concern at what looks to be an increasing death rate in those under 30, other than this these figures are similar to 2021.

Female suicides and shift in trends

There was a concerning increase in deaths by suicide in females seen in early 2020 which continued over the following months. A subgroup was set up to explore these deaths in more detail, gather more information from GPs and attempt to spot any trends and patterns in these deaths. Deaths in females have subsequently returned to pre-2020 levels, although the overall deaths by suicide in Berkshire has remained stable meaning male suicides are now increasing and requires attention

The female suicide subgroup that feeds into the Pan Berkshire Partnership Group will continue to meet under a new title that looks to start to explore and address occurring trends and patterns as they occur. These will include male deaths, deaths related at sodium nitrate and nitrite and the age-related trends

14.11 The Pan Berkshire Ten Point Plan

The Pan Berkshire SP Partnership has identified 10 Key Initial Actions across four key domains to address the regional development needs as set out in section 12 above.

The key domains for regional activity are:

Prevention
Awareness & Training
Collaboration
Evidence

The 10 Key initial actions at a Regional level are:

1**. Introduce suicide prevention across all policy areas**

2. Improve methods to tackle root cause vulnerability

3. Establish a trauma informed approach

4. Assess and strengthen ways of tackling inequalities

5. Establish focus on debt and cost of living

6. Improve focus on children and young people

7. Establish means to address female suicide rates 8. Strengthen focus on links between mental health, self-harm and suicide

9. Continue to develop and establish support for people bereaved by suicide

10. Develop means for family support to ensure individual wellbeing

14.11 The Pan Berkshire Workplan

Following the Summit on the 12th of December 2022 we will be reframing a comprehensive workplan informed by the recommendations set out in Appendix B, and the outputs from the Summit and wider consultation.

The Key Actions for the Workplan – harnessing the Vision and Principles and Partnership approach set out above will capture responses addressing the key national, Regional and suggested local actions.

The National Suicide Prevention Strategy Self Harm in 2017 for Suicide Prevention for the UK sets out 7 core recommendations that form the foundation for the Pan Berkshire works.[41] Building upon these an initial ten-point plan outlines key development priorities for the Pan Berkshire system. These - along with the national priorities suggest a range of local development priorities.

Together they frame responses at three levels and with the Recommendations framed in earlier Strategic drafts will be used to develop a comprehensive five-year workplan.

National Strategic Priorities	1. Reduce the risk of suicide in key high-risk groups 2. Tailor approaches to improve mental health in specific groups 3. Reduce access to the 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 7. Reduce rates of self-harm as a key indicator of suicide risk
Pan Berkshire Development Priorities	1 Introduce suicide prevention across all policy (areas) 2. Improve methods to tackle root cause vulnerability 3. Establish a trauma informed approach 4. Assess and strengthen ways of tackling inequalities 5. Establish a focus on debt and cost of living 6. Improve focus on children and young people 7. Establish means to address female suicide rates 8. Strengthen focus on links between mental health, self-harm and suicide 9. Continue to develop and establish support for people bereaved by suicide 10. Develop means for family support to ensure individual wellbeing
Local Suicide Prevention Action planning. **These are suggested actions for local areas to address**	1. Refresh of Local Action Plans and priorities 2. Upskilling of the workforce and community 3. Communication and engagement to share Zero Suicide Alliance and other key resources and concepts 4. Data and local insight works in support of the local and pan Berkshire RTSS and intelligence works 5. Identification of a named Strategic level SP lead to ensure delivery with local Systems and Portfolio Holders 6. Continue to support local data intelligence and analysis works (RTSS and review processes)

Table 1 The National, Regional and Local Suicide Prevention Action Planning

[41] Preventing suicide in England: Third progress report (publishing.service.gov.uk)

Alongside this the Strategy reflects on the need to address the three key areas for local development set out in the PHE Practice and Local Area resource[42]

1. **Establishing a multi-agency suicide prevention group involving all key statutory agencies and voluntary organisations**
2. **Completing a suicide audit**
3. **Developing a suicide prevention strategy and/or action plan that is based on the national strategy and the local data**

As mentioned the Consultation on the Strategy will inform the suggested approach to Regional and local works - including the suggested areas for action to refresh or contribute to works that are already underway in each local authority area.

This consultation Draft, with its revised approach to the partnership and Local area support and a refreshed Workplan - will be informed by the consultation - are direct responses to National, Regional and Local needs.

The Workplan will - **subject to consultation** - initially focus on a new audit and needs assessment and building the new partnership structure and the supportive offers at pan Berkshire level as set out above and below. Alongside this the Partnership structure will be established and Terms of Reference generated to agree the scope and remit of the groups and partnership and the level of support required for Local Areas.

The Workplan will also address – subject to the feedback received in the consultation - potential Regional or Local area responses to the Prevention Concordat for Better Mental Health and or a specific suicide prevention orientated pledge for either Berkshire wide or local areas to engage with.

We are clear that there are a wide range of county wide opportunities for the Pan Berkshire works to support Local Works ranging from a refreshed Suicide Audit in 2023 to system level suicide prevention training and community facing suicide prevention awareness and communications in support of Local Action plans. Initial Pan Berkshire works that are being suggested include:

- Local Area Showcases – each borough presents what they are working on - safe space to share local actions & Challenges faced in delivery across the Lifecourse
- Action planning for SP – Best practice, National, Regional and local Best Practice
- Leadership in your local system –Working across the complex NHS and LA/democratic systems to achieve change
- Economic impacts - what can we do differently to try to stop the cost-of-living crisis have a negative impact on SP
- Suicide Cluster Identification and Action Planning

[42] PHE_LA_Guidance_25_Nov.pdf (publishing.service.gov.uk)

- Postvention in Schools and workplaces
- Raising Awareness of SP from RSE in schools to the adult facing workforce – What works in showcase materials and service offers
- SP Sensitive Communications – What we Share and How we Share
- State of the Art Suicide Prevention - - Emerging Best Practice
- What are NCISH and NCMD telling us about trends and actions to address
- Suicide and Faith – Working with Communities across the different faith groups
- Towards a Resilient Workforce and Community: Training our workforces to work with death - what do we need to do to protect our workforces (statutory and voluntary)
- How we can learn from the Bereaved - Bereavement Experience Measures an overview

The Consultation will aim to understand what supportive inputs are required by the Berkshire system and how they should be prioritised – taking into account available resources and local priorities arising form Local Action Planning.

14.12 The Cube:

The Cube is a model framework to share tools and resources to help those who Self-Harm and to support and strengthen the suicide prevention offer in Berkshire (Appendix C). Taking its structure from a Cube shape the resource is a framework setting out a series of resources designed to present information on Self Harm and Suicide Prevention

1. **Public facing – "I need help"**
2. **Public Facing - I need to help someone"**
3. **Public – "I want to get involved"**
4. **Professional - Data, Research, Resources, Protocols and Training**
5. **Professional – Local Strategy and Links to place based partnerships and plans**
6. **Crisis Pathway & Suicide Prevention - Data, System contacts, safeguarding, and Child Death Review, LEDER[43], etc.**

Users enter the resource via the face of the Cube that aligns to your need at the time - with three public and three professional entry points linking together to provide a coherent framework and in time comprehensive resource to help the public and professionals tackle the linked agendas of Self Harm and Suicide Prevention. The Cube is meant for both public and professionals who are looking for more information, resources and advice that will help them understand the Self-Harm support and the Suicide Prevention agenda.

[43] LEDER - the NHS Learning Disability Mortality Review

14.13 The Local Picture

Berkshire Suicide Audit (2018)

The most recent Berkshire Suicide Audit covered coroner conclusions across the period 1st April 2014 through to 31st March 2018 and included a review of 241 hearings.

- The Berkshire profile broadly matched the national profile in terms of gender.
- Some age variations were noted but not at a statistically significant level.
- No statistically significant difference was found between suicide rates in areas of relative deprivation in Berkshire.
- Most people included were either in full-time work (24%), unemployed (20%) or retired (18%).
- 80% of all of those who were employed had a job title recorded and 43% of these worked in a skilled trade.
- 6% of all people included were recorded as being in education at the time of death.

The 2018 Audit highlighted the following personal and social factors as seen on a recurring basis in inquest reports:

- Relationship difficulties (67%)
- One or more mental health diagnosis (63%)
- One or more physical health condition (61%)
- History of self-harm (21%)
- Work-related stress (20%)
- Financial issues (19%)
- Involvement with police or courts (15%)
- Bereavement by suicide (6%)

This information is helpful in identifying risk factors which can help to target local interventions and signposting to support services to work towards preventing deaths by suicide.

The 2018 Audit included a review of which services individuals were known to have been in contact with.

- 10% of all individuals were known to substance misuse services in their lifetime. 20% had a documented history of alcohol misuse and 17% had documented history of drug misuse.
- 51% of those who died and who were registered with a GP had seen their GP within 1 month prior to the date of death (compared to 45% nationally).
- 36% of all deaths occurred to people known to mental health services (compared to 33% nationally), and 31% of individuals had been in contact with mental health services in the 12 months prior to their death (compared to 30% nationally).

This information is particularly useful in identifying which agencies to target for suicide prevention activities such as awareness training for staff, as well as potential locations for signposting material. It should be noted that the 2020-21 deep dive analysis of female suicides (see below) suggests some changes in health support seeking behaviour since this audit was completed.

Berkshire 0-25 Audit (2020)

NHS England has co-ordinated a series of reviews into deaths from suicide by children and young people, including a Berkshire audit of people aged 0-25 who died by suicide in the period 2015-20. This focused work helps to mitigate against the risk of issues particularly pertinent to young people getting overlooked in an all-age approach, within which deaths by younger people are a minority.

For the Berkshire 0-25 Audit, information was drawn from the Child Death Overview Panel (CDOP), Berkshire Healthcare Foundation Trust, Thames Valley Police, and the Coroner's Office. A total sample of 35 young people were included in the analysis. Analysis around ethnicity; and wider experience of adversity, trauma, and socio-economic risk factors were based on the CDOP qualitative sample of 7 young people.

Key findings of the audit are highlighted below with an acknowledgement that caution needs to be given when deriving patterns from a relatively small sample size.

- Females were over-represented by comparison with national data (a trend mirrored in the female deep-dive analysis summarised below)
- The Berkshire age profile did not align with the national picture, but indicated local peaks in the 15-19 and mid 20s age ranges
- Young people from black or minority ethnic groups were over-represented by comparison to national data
- Data on faith, gender identity and sexuality were difficult to source
- Adverse childhood experiences (which includes domestic abuse, parental separation, involvement with criminal justice, poverty within this audit) – were noted in 71% of cases
- Neurodiversity was an identified risk factor
- Postvention support for young people following a suicide attempt was indicated as an area for development.

The six Berkshire Local authorities all have or are in the process of establishing and refreshing Local Action planning, and a new Suicide Audit planned for 2023.

15 Vulnerable Groups

National, Regional and Local works point towards several key groups who will be priorities for both County wide and Local works. Suicide Prevention **works must meet the needs of the whole community (Universal Proportionalism)**[44] but there are groups or cohorts that require additional or specialised focus. The Pan Berkshire Workplan will - alongside the development actions set out above seek to raise awareness of and support the needs of the people from these Vulnerable Groups. **See Appendix C** for an overview of the Vulnerable Groups which includes CYP, Men and Women, Neurodiverse people, LGBTQ, Black and minoritised communities, and those living in Deprived areas or facing challenging economic circumstances

[44] Marmot Review report – 'Fair Society, Healthy Lives | Local Government Association

and who have experienced trauma, abuse or bereavement, including Domestic Violence.

Initial suggested priority works include:

- People transitioning from NHS Mental Health Inpatient Settings
- People from Black and Minority Ethnic Communities,
- Disabled CYP and Adults
- Neurodiverse CYP and Adults,
- LGBTQ plus CYP and adults,
- The Perinatal Mental health agenda
- Survivors and or Perpetrators of Domestic Violence,
- Children Looked After and Care Leavers,
- Survivors of Sexual Exploitation and Abuse
- Older People at risk of Loneliness and Isolation
- Substance Misuse Related Suicides
- People of all ages known to the Criminal Justice System

The Consultation will aim to understand the key priority groups in Berkshire and how they can be prioritised for the Suicide Prevention works that are proposed at regional and Local level.

Appendices

Appendix A - The Pan Berkshire Suicide Prevention Partnership and Contributors to the Draft Strategy

Appendix B Recommendations from the 2021 Draft Strategy

Appendix C Vulnerable Groups