GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

GREATER MANCHESTER HEALTH AND SOCIAL CARE STRATEGIC PARTNERSHIP BOARD

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Date: 24 February 2017

Subject: GM Suicide Prevention Strategy

Report of: Andrea Fallon, Chair of the GM Suicide Prevention Executive & Director of Public Health and Wellbeing, Rochdale Borough Council.

Warren Heppolette

PURPOSE OF REPORT:

The purpose of the report is to present to the board the Greater Manchester Suicide Prevention Strategy 2017-2022 as per the commitment made within the delivery plan of the Greater Manchester Mental Health Strategy, and seek endorsement of the Board to move to implementation.

RECOMMENDATIONS:

The Strategic Partnership Board is asked to:

- Endorse the GM Suicide Prevention Strategy and support the move toward implementation.
- Support the Suicide Prevention Executive in seeking high level sponsorship for Suicide Prevention in Greater Manchester.
- Support the implementation of the Strategy from 1 March 2017.

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1.0 BACKGROUND

1.1. In 2014, 277 people took their own life in Greater Manchester. Suicide is the biggest killer of men under 49, and it remains the leading cause of death in our city region for people aged 15 to 29.

1.2. The majority who die by suicide (two thirds) are not in contact with mental health services, so suicide prevention is a shared public health and mental health priority. For every person who dies, another nine individuals will have attempted suicide hence each suicide can be considered a reflection of underlying levels of poor mental health in our population. In addition, each death has a ripple effect within families and communities, resulting in the lives of at least 10 others being seriously affected to the extent that they are likely to find it difficult to work, to form relationships and live to their full potential. It will also increase their own risk of suicide.

1.3. In this wider social context, the economic cost of each suicide is estimated to be £1.5m, thus suicide is a significant social and economic burden for Greater Manchester. Risk factors for suicide include men, individuals aged 35 – 49, a recent history of self-harm, people in the care of mental health services, those with relationship problems and people in contact with the criminal justice system. Some occupational groups are at higher risk such as doctors, nurses, farmers and veterans, and in young people, bullying, family factors, social isolation and academic pressures increase risk.

1.4. This strategy builds on an existing programme of work, and sets out a bold and ambitious five year plan for reducing and ultimately eliminating suicides in Greater Manchester. To do this will require our co-ordinated efforts so that suicide prevention becomes ‘everyone’s business’.

1.5. We have sought direction from the National Confidential Inquiry into Suicidesand Homicides (2016), the National Suicide Prevention Strategy (2012, updated 2017), the Five Year Forward View for Mental Health, and the recently published PHE resource for local Suicide Prevention Planning. In doing so we have developed a plan for action which fits with the national guidance and PHE resource resulting in our actions being organised around six key objectives:

- All ten Boroughs (and Greater Manchester as a whole) will achieve **Suicide Safer Communities Accreditation** (the ‘nine pillars of suicide prevention’) by 2018

- Mental Health Service Providers will collaborate to work toward the **elimination of suicides for in-patient and community mental health care settings** by continuous quality improvement in relation to 10 key ways for improving patient safety

- We will **strengthen the impact and contribution of wider services**
- We will offer **effective support to those** who are affected
- We will **develop and support our workforce** to better assess and support those who may be at risk of suicide
- We will use the **learning from evidence, data and intelligence** to improve our plan and our services.

2.0 AREAS OF INTEREST FOR YEARS 1 AND 2

2.1. We wish to strengthen local political leadership by:

- Gaining a senior level political champion in Greater Manchester by April 2017.
- Gaining a political champion for each borough by October 2017

2.2. We intend to focus on those deaths that may be most preventable such as:

- Individuals in the care of mental health services
- Individuals with depression
- Individuals with a history of self-harm

2.3. We intend to strengthen our intelligence (and use thereof) relating to suicide in Greater Manchester for example by:

- Scoping the potential for a GM approach to using 'real-time data'
- Undertaking a Greater Manchester Audit of Suicide (underway)

2.4. We also intend to strengthen our response to bereavement support for example by:

- Developing a model care pathway for bereavement support in partnership with Public Health England.
- Undertaking a mapping exercise of available support services across GM

3.0 GOVERNANCE

3.1. The delivery of the strategy will be co-ordinated by the GM Suicide Prevention Executive, and will report on progress using a programme management approach to the GM Health and Social Care Partnership Board via the GM Mental Health Implementation Executive.

4.0 RECOMMENDATIONS

4.1. The Strategic Partnership Board is asked to:

- Endorse the GM Suicide Prevention Strategy and support the move toward implementation.
- Support the Suicide Prevention Executive in seeking high level sponsorship for Suicide Prevention in Greater Manchester.
- Support the implementation of the Strategy from March 1 2017.

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NHS in Greater Manchester

Greater Manchester

Suicide Prevention Strategy

2017-2022

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On behalf of	The GM Mental Health Strategy Implementation Executive

1.0 FOREWORD

Each day in the UK, around 13 people take their own life. This is a tragic loss for those who have died, and the devastating effects of each of these deaths are felt far and wide in families, communities, workplaces and schools. Most of all, the impact is felt most acutely for those loved ones who are left behind feeling bereaved, often bewildered and in most cases searching for answers as to what they could have done or said that might have made a difference. The suicide of someone we know has a profound long term impact on our lives, including our ability to work, to enjoy life, and have satisfying relationships. It also raises our own risk of suicide.

There are marked differences in suicide rates according to social and economic circumstances, so suicide is also a marker of how fair our society is. Those who are out of work, in poor housing, and or with a significant health issue (particularly those who are dependent upon drugs and alcohol) are more at risk. Reducing risk requires system change to address the wider determinants of mental health in addition to high quality health and social care in its widest sense. This presents us with a considerable challenge at a time when resources are more stretched than ever.

In February 2015, the 37 NHS organisations and Local Authorities in Greater Manchester signed a landmark devolution agreement with the Government to take charge of health and social care spending in our City region. This has offered a unique opportunity for us to tackle the challenges we face together through our collective efforts. It facilitates the sharing of learning and resources and offers us an unprecedented mandate to break down organisational barriers to ensure clients and residents are at the centre of everything we do. It allows us to work in closer partnership with local people in the design of services, and allows us to support people in taking ownership and control over their own lives so that they can stay well, and take an active part in enhancing the resilience of their communities.

This suicide prevention strategy has been set out in the spirit of the devolution agreement and fits our vision in Greater Manchester for the greatest and fastest improvement in health, wealth and wellbeing of residents. It has been developed in partnership with a wide network of partners, who have collaborated to develop this strategy.

In developing our strategy we have taken inspiration from the ‘best of the rest’ elsewhere, and thus we take opportunity here to acknowledge the excellent work of all our all colleagues working on this agenda across the UK and thank them for sharing their work.

It is clear that nationally our collective goal is that no-one will see taking their own life as a solution, and to this end our commitment in Greater Manchester is that we will do everything in our power to achieve this.

Andrea Fallon, Chair of the Greater Manchester Suicide Prevention Executive

Lead Director of Public Health for Mental Health (on behalf of the ten Directors of Public Health in Greater Manchester)
& Director of Public Health and Wellbeing, Rochdale Borough Council

2.0 EXECUTIVE SUMMARY

The number of deaths to suicide in Greater Manchester is significant, with 277 deaths occurring in 2014 alone. The majority of suicides occur in men, with increased risk seen in those within the lowest socioeconomic groups and living in the most deprived geographical areas. Other at risk groups include those who self-harm, children and young people and those with untreated depression. Individuals who have been bereaved by suicide, those who are isolated, and those who misuse drugs and alcohol are also at increased risk.

Only a third of all suicides occur in individuals who are known to mental health services, thus preventing suicide requires a co-ordinated whole system approach.

This strategy builds on our work to date and sets out a bold and ambitious five year plan for reducing and ultimately eliminating suicides in Greater Manchester. To do this will require our co-ordinated efforts so that suicide prevention becomes 'everyone's business'.

We have sought direction from the national Suicide prevention strategy from 2012, the Five year Forward View for Mental Health, and the recently published PHE resource for local Suicide Prevention Planning. In doing so we have developed a plan for action which fits with the national guidance and PHE resource, and we have organised our actions around six key objectives:

1) All ten Boroughs (and Greater Manchester as a whole) will achieve **Suicide Safer Communities Accreditation** (the 'nine pillars of suicide prevention') by 2018
2) Mental Health Service Providers will collaborate to work toward the **elimination of suicides for in-patient and community mental health care settings** by continuous quality improvement in relation to 10 key ways for improving patient safety
3) We will **strengthen the impact and contribution of wider services**
4) We will offer **effective support to those** who are affected
5) We will **develop and support our workforce** to better assess and support those who may be at risk of suicide
6) We will use the **learning from evidence, data and intelligence** to improve our plan.

3.0 WHAT DO WE WANT TO ACHIEVE?

Our vision is that no-one will see suicide as a solution, and our ambition is therefore that there will be no more suicides in Greater Manchester.

We recognise that from the evidence we have, some suicides might be considered to be the most preventable although we firmly believe that all are avoidable. With this in mind, our strategy sets out our plan to ensure that we harness the support and contribution of all services and agencies so that we can reduce risk, proactively intervene when needed, and effectively respond to those in crisis.

Our primary focus for the first two years of our strategy (2017/18 – 2019/20) will be to meet the challenge set out within the Five Year Forward View for Mental Health ie. to reduce the rate of suicide by 10% by 2020. Thereafter we will seek to stretch this target further.

4.0 WHAT IS THE PURPOSE OF THIS DOCUMENT?

This document sets out our strategy for preventing suicide in Greater Manchester. In this strategy we set out a bold ambition that there will ultimately be no more suicides, with an initial focus on meeting the challenge set out within the Five Year Forward View for Mental Health for at least a 10% reduction by 2020. In order for this to be achieved, every borough in Greater Manchester will need to support this strategy.

Our strategy is intended to stimulate a social movement for change in the way we think and act in relation to suicides and suicide prevention. We aim to enhance the skills of our wider workforce in relation to assessing and managing risks and supporting those who are affected or bereaved, to reduce the stigma attached to talking about suicide and mental health more openly, and to promote suicide safer communities.

5.0 WHY HAVE A SUICIDE PREVENTION STRATEGY?

5.1 Key drivers

Suicide is a major mental health, social, economic, and public health issue. It is a cause of early death and an indicator of underlying poor mental health at population level and represents a devastating loss for individuals, families and communities and carries a huge financial burden. The highest numbers of suicides are found in men aged 35 – 54 years, and in women aged 40-59 years.

By 2020/2021 our Greater Manchester health and social care system faces an estimated financial deficit of £2bn indicating the need for radical transformation. The impacts of mental health on our wider health care system are considerable: we know that poor mental health worsens physical illness and raises total health care costs by at least 45%, for example, an estimated 12% - 18% of all NHS expenditure on long-

term conditions is linked to poor mental health and wellbeing (between £420m and £1.08bn in Greater Manchester alone).

Improving the mental health of our residents is therefore a high priority for Greater Manchester. Our broader plans for how we will do this are set out within the Greater Manchester Mental Health and Wellbeing Strategy[i] and within this, suicide prevention is identified as a year one/two priority for delivery.

Most importantly, this strategy recognises that suicide has a significant toll on others – i.e. estimates suggest that for every person who dies from suicide at least 10 people are directly affected. Also for each case of suicide we know that there are around nine others that will have been attempted. Thus each suicide is an indication of a significant number of individuals who need help and support.

The key national driver for the development of local suicide prevention strategies and action plans was set out within the 2012 strategy for England *Preventing Suicide in England, a cross government strategy to save lives*[1]. The requirement for a comprehensive local suicide strategy is considered to be an effective mechanism in reducing deaths by suicide by supporting the combination of a range of interventions. More latterly, the Five year forward view for Mental Health[2] set a requirement for all local areas to have Suicide Prevention plans in place by 2017.

5.2 The benefits of a Greater Manchester approach to Suicide Prevention

This strategy reflects a call to action to all Greater Manchester agencies and communities to come together to join forces to tackle a significant threat to the health and wellbeing of our residents. We have taken an all-age approach, recognising that risk varies across the life-course and that prevention requires a range of interventions, some of which are tailored to need and some demographic groups

We acknowledge the increased emphasis on self-harm, primary care, prisons and other at risk groups within more recent policy documents in relation to suicide prevention. We have not attempted to present all actions for each priority area here as these are the focus of subject specific comprehensive plans, each led by expert leads from within the Suicide Prevention Executive Group. In preference we have looked at broader priorities and objectives that can be effectively supported by a Greater Manchester approach.

In line with the ethos of other Greater Manchester Plans, we are interested in whole system and asset based approaches as these are most likely to foster effective partnerships between local authorities, primary care, prisons and probation, mental health services, voluntary organisations and local people affected by suicide. Importantly the Greater Manchester devolution arrangement offers us the best opportunity to date in scaling up activities which have been successful in some boroughs to every borough where it makes sense to do so.

[1] Preventing Suicide in England: A cross government strategy to save lives (2012) https://www.gov.uk/government/publications/suicide-prevention-strategy-for-england
[2] The five year forward view for mental health (2016)

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

5.3 Priorities for Greater Manchester Suicide Prevention

Our plan supports us in focusing on all six areas of the national strategy in the long-term, however our priorities for a whole system approach in the short term are[3]:

a. **Reducing the risk in Men**
b. **Preventing and responding to self-harm**
c. **Children and young people and women during pregnancy and postnatally**
d. **Treating Depression in Primary Care**
e. **Acute Mental Health Care Settings**
f. **Tackling High Frequency Locations**
g. **Reducing Isolation and Loneliness**
h. **Bereavement Support /Postvention**

6.0 THE NATIONAL AND LOCAL PICTURE

6.1 National

The recent publication of the 2016 National Confidential Inquiry into Suicide and Homicide by People with Mental Illness[7] (NCISH) shows that suicide is the biggest killer of men under 49 and it remains the leading cause of death in people aged 15-29 [4]. The majority of people (two thirds) who die by suicide are not in contact with mental health services[5] and in England one person dies as a result of suicide every 2 hours.[6]

For every one person who dies from suicide, at least 10 others are directly affected. In 2014, there were 4882 deaths from suicide in England, of which 277 were in Greater Manchester. From 2004 to 2014 there was a 30% fall in suicide rates in men aged 25 to 34. However since 2006, suicide rates in men aged 45-54 have risen by 27%, and in men aged 55-64 rates have risen by 20%. We also know that specific

[3] Appleby,L (2016) 'Priorities for Suicide Prevention action plans' in Local Suicide Prevention Planning – A Practical Resource. Public Health England.
[4] Office of National Statistics, What do we die from? (2015)
[5] HM Government Preventing suicide in England A cross-government outcomes strategy to save lives (2012)
[6] Self-harm, suicide and risk: helping people who self-harm (2010) Royal College of Psychiatrists

groups appear to be at higher risk. The following risk factors have become more common as antecedents to suicide:[7]

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

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

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

The report also indicates that in the UK, the highest rates of suicide as a whole are in Northern Ireland, with rates in England and Wales being higher post 2009, and the rate in Scotland appearing to be falling. The only area in England where rates didn't appear to increase after the recession were in London. Across England, this increase translates to an additional 250 deaths each year.

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

An increase in suicides under the care of crisis teams is clear from the data which is considered to be as a result of pressure on the system ie as a consequence of community crisis teams taking on more complex clients as a result of scarcity of in-patient beds.

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

6.2 Greater Manchester

[7] Appleby L et al (2016) National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. The University of Manchester. Commissioned by the Healthcare Quality Improvement Partnership (HQIP)

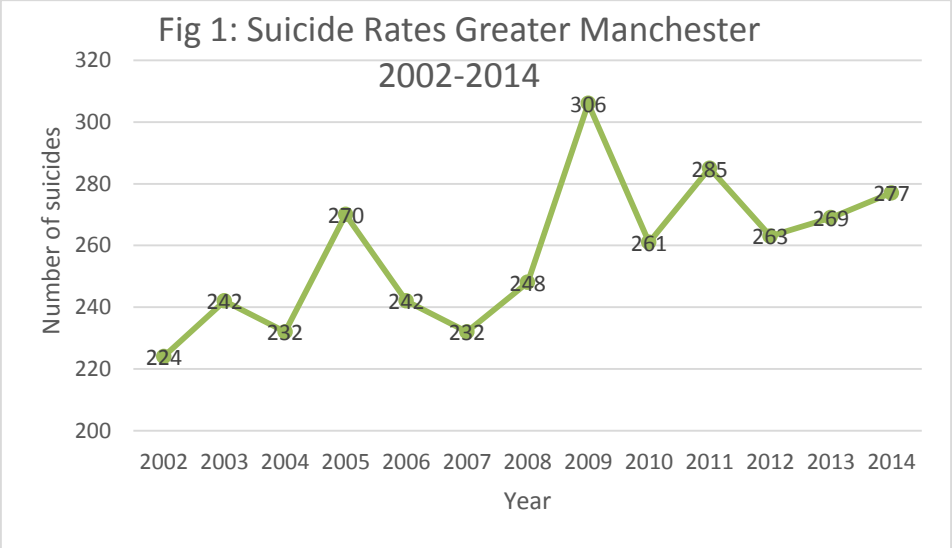
The total population of Greater Manchester is approximately 2.8million people. In 2014 there were 277 [8] deaths by suicide in Greater Manchester, this is 277 too many. Perhaps unsurprisingly the greatest number (48) were seen in the city of Manchester, with the lowest in Trafford (N=13) (table 1)

Table 1 Numbers of suicides by Borough (2014)

Local Authority	Count
Bolton	24
Bury	30
Manchester	48
Oldham	26
Rochdale	31
Salford	27
Stockport	26
Tameside	23
Trafford	13
Wigan	29
Greater Manchester	**277**

Of the 4882 deaths from suicide in England in 2014, suicides in Greater Manchester constituted around 5.7% of these, reflecting the significant local and national burden of mental ill-health within the population.

As for the national picture, overall rates in Greater Manchester have been rising since 2002, with a peak seen in 2009 (Fig 1). The overall rate of suicide for Greater Manchester between 2012 and 2014 was 10.3 (per 100,000 residents)[9] with significant variation between boroughs, and between different population groups.



[8] ONS Suicide registrations by Local Authority
http://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/suicidesbylocalauthority
[9] Appleby L et al (2016) National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. The University of Manchester. Commissioned by the Healthcare Quality Improvement Partnership (HQIP)

In 2014, individual boroughs in Greater Manchester took part in a sector led-improvement initiative, which set out to bench mark activity against the recommendations of the 2012 strategy and share good practice across the sector. An intended benefit from the process was for boroughs to explore different approaches, and to share data and information.

A key finding was that although all boroughs had undertaken local suicide audits at some point, not all were undertaken routinely either annually or bi-annually, and some may be insufficient to effectively assist with prevention planning. Not having undertaken a recent audit was generally linked to a lack of capacity, but importantly feedback suggested that suicide audits may be better undertaken (from a statistical perspective) on a larger spatial scale, ideally at GM level and to a standardised format so as to enable more meaningful comparison.

6.3 Key risks in relation to suicide

An understanding of the key risks in relation to suicide enables targeted approaches to those most in need of intervention. A number of local suicide audits suggest that Greater Manchester fits the national picture with regard to overarching demographic, social and economic factors which place residents at higher risk of suicide.

Men are three times more likely to die by suicide than women as in the UK[10] and people in the lowest socio-economic group and living in deprived areas appear to be more at risk of suicide than those in the most affluent groups living in the most affluent areas.[11] A more detailed analysis of suicides at GM level is intended through the undertaking of a GM wide audit although this is not without its challenges due to the slightly different methods used across the ten boroughs.

Of interest nationally is that a newly emerging group at high risk appear to be recent migrants, who face multiple features of social adversity, and this group may be of interest for targeted interventions going forward. National evidence suggests that those most at risk are:

- Men
- Individuals aged 35-49
- People with a recent history of self-harm
- People in the care of mental health services
- People in contact with the criminal justice system
- Specific occupational groups, such as doctors, nurses, veterinary workers, farmers and agricultural workers[12] and veterans.

The incidence of self-harm as an antecedent to suicide has seen a steep rise, calling for better assessment of those presenting to services. In 2014/15 there were 7,116

[10] http://web.ons.gov.uk/ons/rel/subnational-health4/suicides-in-the-united-kingdom/2014-registrations/
[11] Platt, S. Inequalities and suicidal behaviour; In O'Connor, R.C. et al. International handbook of suicide prevention: research, policy and practice. 2011
[12] Op.cit. HM Government (2012)

hospital admissions due to self-harm[13]. Of these, evidence suggests that patients can often present with a complex history of risk factors and events leading up to admission including:

- Untreated depression
- Unemployment
- Debt
- Relationship breakdown and bereavement including by suicide
- Drug and alcohol misuse
- Social isolation [14]

Key risk factors for the under 25s are:[15]

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

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

- Effective coping and problem solving skills
- Presence of reasons for living, hopefulness and optimism
- Physical activity and health
- Family connectedness
- Supportive schools and Social support
- Religious participation, Employment
- Lack of exposure to suicidal behaviour
- Traditional social values
- Access to health treatment [16]

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

7.0 STRATEGIC APPROACH

7.1 National Strategy

[13] PHE Public Health Profiles (2015)
[14] PHE Local suicide prevention planning A practice resource (2016)
[15] National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) Suicide in children and young people. (2016)
[16] Scottish Government Social Research Risk and Protective Factors for Suicide and Suicidal Behaviour: A Literature Review (2008)

The Five Year forward view for Mental Health (2016) sets out the challenge to reduce suicides by 10%, and several strategies around the UK have clearly stated their intent to go much further than this – toward a zero suicide approach. This too is our ambition. We intend to adopt a focused approach to achieving this goal by targeting those deaths which are most preventable by identifying specific at-risk groups, communities or settings for action.

We will use the intelligence gathered via the GM Suicide Audit to inform where our efforts might be best targeted in addition to national priority groups.

This approach is founded on the principle that 'the sum of marginal gains' is likely to be the most effective means of meeting our vision for no more suicides in Greater Manchester and will foster a highly targeted and effective approach.

This strategy acknowledges and builds on a substantial body of work in relation to suicide prevention in Greater Manchester and reflects the learning of a programme of sector led improvement undertaken in 2013. Our overarching objectives are aligned with the six national priorities (2012) and national refresh (2017).

During 2015 and 2016 each of the ten boroughs has been working to develop and deliver a transformational 'Locality Plan' which set out how the ambitions set out within 'Taking Charge of Health and Social Care in Greater Manchester' will be delivered in each borough.

Most of the work aligned to the priorities for suicide prevention are incorporated in the locality plans for each borough. The strategic priorities for Greater Manchester are set out below and this strategy principally focuses on actions that support those objectives which can be delivered or supported by utilising a Greater Manchester approach

7.1.1 National Priorities for Action

The National Suicide Prevention strategy of 2012 set out six priority areas for action:

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

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

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

- Better and more consistent local planning and action by ensuring that every local area has a multi-agency suicide prevention plan by 2017, with agreed priorities and actions.

- Better targeting of suicide prevention and help seeking in high risk groups such as middle-aged men, those in places of custody/detention or in contact with the criminal justice system and with mental health services
- Improving data at national and local level and how this data is used to help take action and target efforts more accurately
- Improving responses to suicide
- Expanding the scope of the national strategy to include self-harm prevention in its own right.

7.2 Greater Manchester Mental Health Strategy

7.2.1 The overarching Greater Manchester Mental Health Strategy

This suicide prevention strategy forms part of an overarching strategy for mental health in Greater Manchester. This broader strategy is summarised in appendix 1, and sets out our vision to improve child and adult mental health, narrow the gap in life expectancy and ensure parity of esteem with physical health. Our vision also commits to shifting the focus of care toward prevention, early intervention and resilience and toward delivering a sustainable mental health system. Simplified and strengthened leadership and accountability is at its core, as is the enablement of resilient communities, the engagement of inclusive employers and close partnership working with the third sector.

To achieve these goals we intend to strengthen our mental health system, and we will do this through four key characteristics which run throughout our plans:

- Prevention
- Access
- Integration and
- Sustainability

A number of ‘golden threads’ also run throughout our strategy, including

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

This Suicide Prevention strategy stays true to these principles.

8.0 GREATER MANCHESTER PRIORITIES FOR ACTION

Our key priority areas for action for preventing suicide in Greater Manchester are as described in the recent Public Health England resource for suicide prevention[17]. Following the completion of the GM audit this may be enhanced to reflect findings.

Priorities	More specifically …
1) Reducing the risk in men	In particular middle aged men, with a focus on economic disadvantage such as debt and or unemployment, social isolation and drugs and alcohol misuse. A focus on developing treatment and/or support settings that are more acceptable and accessible by men
2) Preventing and responding to self-harm	A range of services are needed for adults and young people in crisis, and psychological assessment for self-harm patients. Acknowledgement that support for young people will be distinct from that of adults.
3) Mental Health of Children and Young People (and in pregnancy)	Joint working between health, social care, schools and youth services, and includes risk during pregnancy and those who have given birth during the last year. In particular we intend to focus on the increased suicide risk between 15 to 19 year olds.
4) Treatment of depression in Primary Care	Safe prescribing of painkillers and anti-depressants, *(plus skilling up primary care practitioners in identification and initial management of risk)*
5) Acute Mental Health Care	Safer wards and safer discharge (including follow up), adequate bed numbers and no out of area admissions.
6) Tackling High Frequency Locations	Including working with local media organisations and groups to prevent imitative suicides
7) Reducing isolation and loneliness	For example, through community based support, good transport links and by working with the third sector with a particular focus on men and older people
8) Bereavement Support and Media engagement.	The provision of better information and support for those bereaved or affected by suicide and supporting the media in delivering sensitive approaches to suicide and suicidal behaviour

9.0 WHAT WE WILL DO: OUR OBJECTIVES

An overarching and ambitious action plan has been developed to support the delivery of this strategy which following stakeholder feedback is being further

[17] Appleby,L (2016) 'Priorities for Suicide Prevention action plans' in Local Suicide Prevention Planning – A Practical Resource. Public Health England

developed into issue specific work plans. These actions have been structured around six strategic objectives which cross reference our priorities for action (section 8.0) and the national strategy objectives. Below is a summary of our strategic objectives and associated 'pledges' that this strategy makes for 2017-2022.

Strategic Objective 1

All ten Boroughs (and Greater Manchester as a whole) will achieve **Suicide Safer Communities Accreditation** (the 'nine pillars of suicide prevention)' by 2018 i.e.

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

Strategic Objective 2

Mental Health Service Providers will collaborate to work toward the **elimination of suicides in in-patient and community mental health care settings** by continuous quality improvement in relation to the 10 ways to improve patient safety[18] :

1) Safer wards (eg prescribing, eliminating ligature points)
2) Early follow up on discharge (within 2-3 days)
3) No out of area admissions
4) 24 hour crisis teams (sign up to the crisis care concordat)
5) Family involvement in 'learning lessons'
6) Guidance on depression
7) Personalised risk management
8) Outreach teams
9) Low staff turnover
10) Dual Diagnosis services (i.e. Alcohol and Drugs)

Strategic Objective 3

We will **strengthen the impact of wider services by**

[18] Appleby,L et al (2016) Making Mental Health Care Safer: Key findings from the National Confidential Inquiry into Suicides and Homicides. Manchester University.

1) Refreshing the mapping exercise undertaken as part of the sector led improvement programme to inform a directory of services (via an app/website)
2) Developing a GM standard for suicide prevention in secondary care
3) Secure high level GM political support for suicide prevention, with support from local political mental health champions
4) Working with colleagues in schools to raise awareness of emotional wellbeing amongst young people.
5) Working closely with colleagues in maternity services, health visiting and mother and baby units to identify opportunities to improve outcomes for new or expectant mothers with mental health issues.
6) Working with the community and voluntary sector by supporting collaboration such as a voluntary sector Health and Wellbeing Alliance in each borough.
7) Work with prisons and the probation service to address self-harm and suicide amongst offenders
8) Work with substance misuse services to ensure timely access to treatment.
9) Seeking support for the GM strategy and local action plans at each Health and Wellbeing Board and within each locality plan.
10) Seek to strengthen the management of depression in primary care
11) Learn from and strengthen the approaches to suicide reduction and post-vention developed by Network Rail, GMP, Highways Agency and other colleagues as first responders to incidents.
12) Identifying high risk locations and putting plans in place to reduce risks.
13) Being open, receptive and supportive of social movements that improve public awareness of suicide prevention through campaigns or social media platforms

Strategic Objective 4

We will offer **Effective support to those** who are affected

1) In partnership with Public Health England, we will look at the potential for a social marketing initiative that will stimulate a social movement for change with regard to eliminating the stigma associated with suicide and self-harm.
2) We will scope current arrangements across GM in relation to post-vention interventions, eg schools, communities and outreach to family and friends, in addition to bereavement support
3) We will review and continually improve access to IAPT to meet the national targets for those in need of support.
4) We will review local Suicide liaison service provision across GM.
5) We will review local self-harm care pathways against NICE guidance (CG133)
6) We will continue to strengthen our crisis care arrangements so that there is parity of access to 24/7 support for all-age groups especially children.
7) We will develop a Greater Manchester Suicide Bereavement Pathway including population based initiatives, group based and 1-1 interventions.
8) We will scope the potential for additional commissioning of suicide bereavement support to supplement local arrangements
9) We will scope the potential for a GM approach to the use of ‘Real-Time Data’ in maximising our response to suicides.
10) We will develop our processes across GM to foster a culture of learning from suicide attempts and the avoidance of a blame culture.

Strategic Objective 5

We will **develop and support our workforce** to better assess and support those who may be at risk of suicide

1) Promote mental health in our workplaces and amongst our staff, especially those in higher risk occupations, and promote approaches that reduce stigma.
2) Expanding access to a locally developed training programme which supports a greater understanding of the five ways to wellbeing (Stockport/Manchester/Bolton) across GM
3) Increasing knowledge skills and confidence for primary care practitioners and pharmacies, and in management of risks in primary care (eg medicines)
4) We will seek to standardise our care pathways to strengthen consistency across provider organisations.

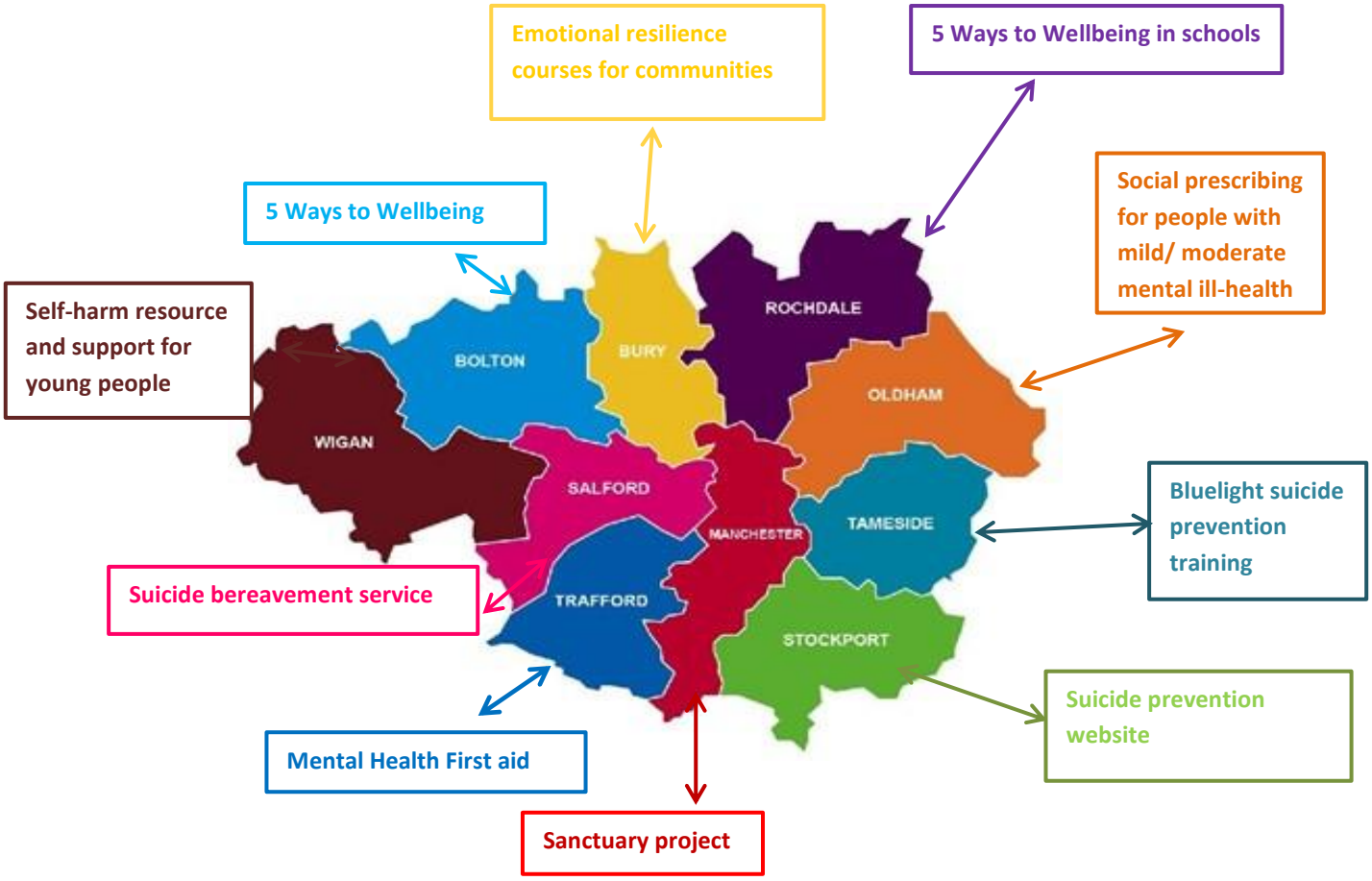
Strategic Objective 6

We will use the **learning from evidence, data and intelligence** to improve our understanding, our communications, our strategy and our services

1) We will undertake a GM audit of suicides every 2 years and share learning across boroughs to identify high frequency locations/groups/means etc.
2) We will work with local faith group leaders to share knowledge and understanding of suicide in relation to culture and faith.
3) We will seek to standardise post-incident reviews
4) We will work with colleagues in the media regarding appropriate reporting of suicide and maximise opportunities to signpost and raise awareness.
5) We will scope the potential for a minimum/optimal standard for risk assessment tools in primary care
6) We will use the audit process to identify high risk locations and or new and emerging means of suicide and put in place plans to reduce related risks.
7) We will hold an annual suicide prevention conference for Greater Manchester to share learning, good practice and strengthen links between agencies
8) We will consult with community and voluntary sector colleagues to identify the distinct needs of specific groups such as LGBT, Asylum seekers, those with a Long-term condition, perinatal care, drugs and alcohol clients and individuals in contact with the justice system to set out plans for improving outcomes in these groups
9) We will review the learning from elsewhere to design a campaign to target men in particular, such as that employed in Kent which focused on barbers.

10.0 WHAT ARE WE BUILDING ON?

Many examples of good practice exist in Greater Manchester with the potential to scale up across the conurbation:



11.0 MONITORING PROGRESS AND IMPACT

Monitoring and evaluation

We will monitor progress against each of our actions as set out within the action plan above, which will be refreshed each year using a programme management approach.

We will also evaluate the impact of the strategy by monitoring the following:

1. Local suicide rates, attempts and rates of admission for self-harm
2. Help-seeking behaviour such as the use of telephone helplines
3. Improvements in waiting times, access and completion rates for treatment of depression.
4. The numbers recorded as experiencing suicidal ideation
5. The use of standard questionnaires to monitor depression and anxiety
6. Monitor the views and experiences of service users
7. Monitor the views of professionals
8. Reduction in the number of GPs who are exempt from the QOF indicator relating to depression (depending on Primary Care Strategy)

Formal reporting on each work stream is be expected by the GM Mental Health Implementation Executive each month.

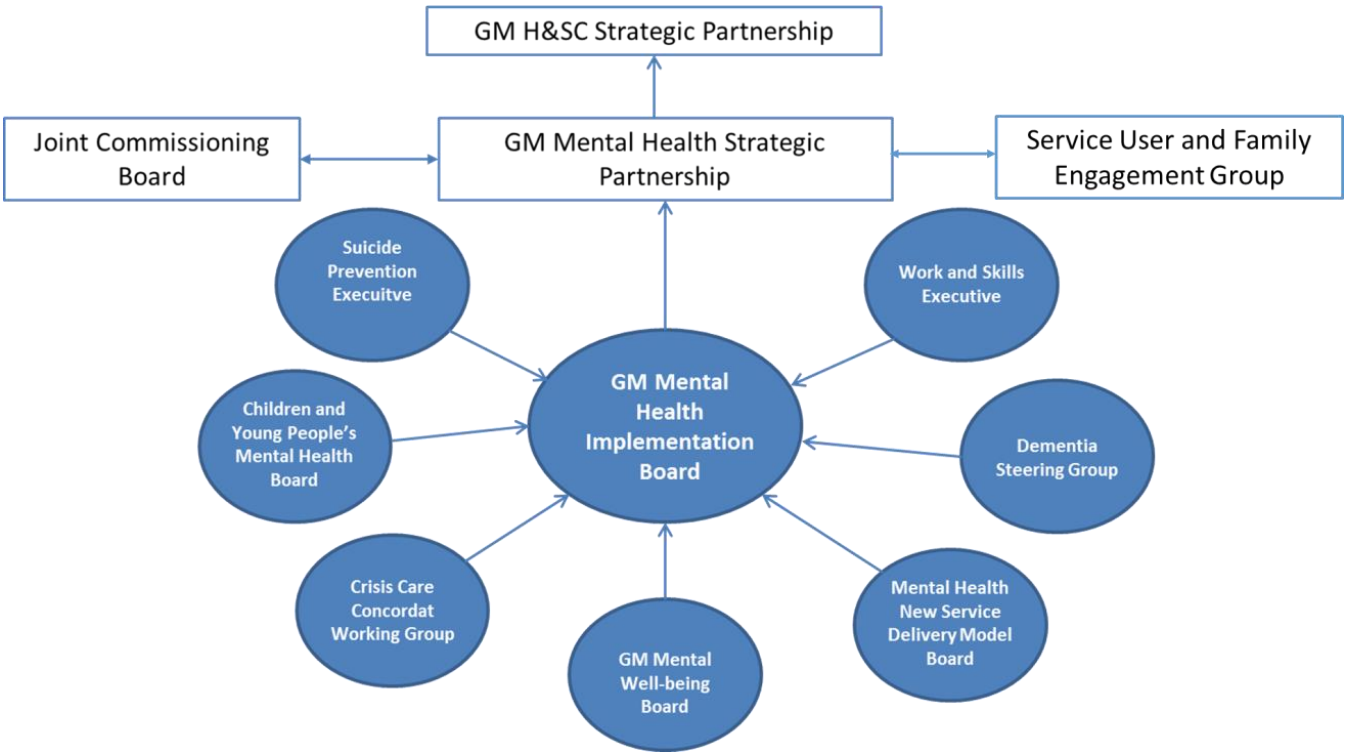
12.0 GOVERNANCE INFRASTRUCTURE

The strategy will be governed by the Greater Manchester Suicide Prevention Executive which will receive monthly updates on progress against each work stream. The suicide prevention work stream is closely aligned to the mental health and wellbeing programme. The strategy will be presented to each Health and Wellbeing Board for comment and support.

Stakeholder feedback will be sought from each of the ten boroughs, and through relevant events where key partners will be able to input into its ongoing development.

A programme management approach will be utilised to focus on delivery and measurement of impact during 2017/8 and 2018/9 which will form the basis of the work of the Suicide Prevention Executive.

A full equality impact assessment has been undertaken in respect of the strategy, and the 'place' of the GM Suicide Prevention Executive within the overall governance framework for implementation of the broader strategic GM Mental Health Strategy for Greater Manchester is set out below



Appendix 1 – Greater Manchester Mental Health Strategy.

Compelling Vision

Strategic Plan on a Page