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Royal Borough of Windsor & Maidenhead

NOTICE

OF

MEETING

HEALTH AND WELLBEING BOARD

will meet on

Tuesday 24 January 2023

at

3.00 pm

by

Virtual Meeting - Online access and on RBWM YouTube

To: Members of the Health and Wellbeing Board

Kirsty Hunt
Service Lead – Electoral and Democratic Services
Issued: 16th January 2023

Members of the Press and Public are welcome to attend Part I of this meeting.
The agenda is available on the Council's web site at www.rbwm.gov.uk or contact the Panel Administrator **Mark Beeley** 01628 796345 / mark.beeley@rbwm.gov.uk

Recording of Meetings – In line with the council's commitment to transparency the Part I (public) section of the virtual meeting will be streamed live and recorded via Zoom. By participating in the meeting by audio and/or video, you are giving consent to being recorded and acknowledge that the recording will be in the public domain.

If you have any questions regarding the council's policy, please speak to Democratic Services or Legal representative at the meeting.

AGENDA

Part I

Item	Subject	Person	Timing	Page No
1.	Apologies for Absence To receive any apologies for absence.	Chairman		-
2.	Declarations of Interest To receive any declarations of interest.	Chairman		5 - 6
3.	Minutes and Actions To consider the minutes and actions of the meeting held on 18th October 2022.	Chairman		7 - 14
4.	Priority Focus - Addressing winter pressures through prevention and supporting self-help To consider the main theme of the meeting: • Introduction: Kevin McDaniel • Children's Services: Lin Ferguson • Healthier Together: Alex Streeter De Diego • Adult Services: Helen Sargeant Dar	Kevin McDaniel Lin Ferguson Alex Streeter De Diego Helen Sargeant Dar		Verbal Report
5.	Suicide Prevention Update To consider the report.	Tracy Daszkiewic Dan Devitt Charlotte Littlemore		15 - 78
6.	Covid-19 response to enquiry update To receive an update.	Carolyn Richardson		Verbal Report
7.	Better Care Fund To receive an update on the Better Care Fund.	Lynne Lidster		Verbal Report
8.	Housing Update To receive an update.	Tracy Hendren		Verbal Report

9.	Future Meeting Dates • Tuesday 4th April 2023 • Tuesday 11th July 2023 • Tuesday 10th October 2023	Chairman		-

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MEMBERS' GUIDE TO DECLARING INTERESTS AT MEETINGS

Disclosure at Meetings

If a Member has not disclosed an interest in their Register of Interests, they **must make** the declaration of interest at the beginning of the meeting, or as soon as they are aware that they have a Disclosable Pecuniary Interest (DPI) or Other Registerable Interest. If a Member has already disclosed the interest in their Register of Interests they are still required to disclose this in the meeting if it relates to the matter being discussed.

Any Member with concerns about the nature of their interest should consult the Monitoring Officer in advance of the meeting.

Non-participation in case of Disclosable Pecuniary Interest (DPI)

Where a matter arises at a meeting which directly relates to one of your DPIs (summary below, further details set out in Table 1 of the Members' Code of Conduct) you must disclose the interest, **not participate in any discussion or vote on the matter and must not remain in the room** unless you have been granted a dispensation. If it is a 'sensitive interest' (as agreed in advance by the Monitoring Officer), you do not have to disclose the nature of the interest, just that you have an interest. Dispensation may be granted by the Monitoring Officer in limited circumstances, to enable you to participate and vote on a matter in which you have a DPI.

Where you have a DPI on a matter to be considered or is being considered by you as a Cabinet Member in exercise of your executive function, you must notify the Monitoring Officer of the interest and must not take any steps or further steps in the matter apart from arranging for someone else to deal with it.

DPIs (relating to the Member or their partner) include:

- *Any employment, office, trade, profession or vocation carried on for profit or gain.*
- *Any payment or provision of any other financial benefit (other than from the council) made to the councillor during the previous 12-month period for expenses incurred by him/her in carrying out his/her duties as a councillor, or towards his/her election expenses*
- *Any contract under which goods and services are to be provided/works to be executed which has not been fully discharged.*
- *Any beneficial interest in land within the area of the council.*
- *Any licence to occupy land in the area of the council for a month or longer.*
- *Any tenancy where the landlord is the council, and the tenant is a body in which the relevant person has a beneficial interest in the securities of.*
- *Any beneficial interest in securities of a body where:*
  a) that body has a place of business or land in the area of the council, and
  b) either (i) the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body ***or*** *(ii) the total nominal value of the shares of any one class belonging to the relevant person exceeds one hundredth of the total issued share capital of that class.*

Any Member who is unsure if their interest falls within any of the above legal definitions should seek advice from the Monitoring Officer in advance of the meeting.

Disclosure of Other Registerable Interests

Where a matter arises at a meeting which ***directly relates*** to one of your Other Registerable Interests (summary below and as set out in Table 2 of the Members Code of Conduct), you must disclose the interest. **You may speak on the matter only if members of the public are also allowed to speak at the meeting** but otherwise **must not take part in any discussion or vote on the matter and must not remain in the room unless you have been granted a dispensation**. If it is a 'sensitive interest' (as agreed in advance by the Monitoring Officer), you do not have to disclose the nature of the interest.

Other Registerable Interests:

a) any unpaid directorships
b) any body of which you are a member or are in a position of general control or management and to which you are nominated or appointed by your authority
c) any body
(i) exercising functions of a public nature
(ii) directed to charitable purposes or
(iii) one of whose principal purposes includes the influence of public opinion or policy (including any political party or trade union)

of which you are a member or in a position of general control or management

Disclosure of Non- Registerable Interests

Where a matter arises at a meeting which ***directly relates*** to your financial interest or well-being (and is not a DPI) or a financial interest or well-being of a relative or close associate, or a body included under Other Registerable Interests in Table 2 you must disclose the interest. **You may speak on the matter only if members of the public are also allowed to speak at the meeting** but otherwise **must not take part in any discussion or vote on the matter and must not remain in the room unless you have been granted a dispensation**. If it is a 'sensitive interest' (agreed in advance by the Monitoring Officer) you do not have to disclose the nature of the interest.

Where a matter arises at a meeting which ***affects*** –

a. your own financial interest or well-being;
b. a financial interest or well-being of a friend, relative, close associate; or
c. a financial interest or well-being of a body included under Other Registerable Interests as set out in Table 2 (as set out above and in the Members' code of Conduct)

you must disclose the interest. In order to determine whether you can remain in the meeting after disclosing your interest the following test should be applied.

Where a matter (referred to in the paragraph above) ***affects*** the financial interest or well-being:

a. to a greater extent than it affects the financial interests of the majority of inhabitants of the ward affected by the decision and;
b. a reasonable member of the public knowing all the facts would believe that it would affect your view of the wider public interest

You may speak on the matter only if members of the public are also allowed to speak at the meeting but otherwise **must not take part in any discussion or vote on the matter and must not remain in the room unless you have been granted a dispensation.** If it is a 'sensitive interest' (agreed in advance by the Monitoring Officer, you do not have to disclose the nature of the interest.

Other declarations

Members may wish to declare at the beginning of the meeting any other information they feel should be in the public domain in relation to an item on the agenda; such Member statements will be included in the minutes for transparency.

HEALTH AND WELLBEING BOARD
GREY ROOM - YORK HOUSE AT 3.00 PM

18 October 2022

PRESENT**:** Councillor Sayonara Luxton, Huw Thomas (Vice-Chair, in the Chair), Councillor David Coppinger, Councillor Donna Stimson, Anna Richards, Tess Scott, Steve Dunn and Kevin McDaniel

Also in attendance: Councillor Simon Bond, Councillor Gurch Singh, Councillor Gurpreet Bhangra, Ruchi Baxi and Sarah Collin

Officers: Mark Beeley, Marc Connor, Tracy Hendren, Charlotte Fox, David Scott, Rebecca Hatch and Prince Obike

PART I

313/15 APOLOGIES FOR ABSENCE

An apology for absence was received from Councillor Carroll, Councillor Luxton was attending the meeting as substitute. An apology for absence had also been received from Caroline Farrar.

314/15 DECLARATIONS OF INTEREST

There were no declarations of interest received.

315/15 MINUTES AND ACTIONS

RESOLVED UNANIMOUSLY: That the minutes of the meeting held on 12th July 2022 were approved as a true and accurate record.

The Vice Chairman confirmed that there were no actions that needed to be reviewed or brought forward from the November 2021 meeting, when the priority focus on reducing inequalities was last considered by the Board.

Kevin McDaniel, Executive of Place, said that there was a meeting with OPAF to take place shortly, following the action from the previous meeting of the Board in July 2022.

316/15 REVIEW OF TERMS OF REFERENCE

Mark Beeley, Democratic Services Officer, explained that the Health & Wellbeing Board needed to review the Terms of Reference annually. It had been some time since this had been last reviewed and it had been added to the agenda for consideration by the Board. If the Board decided to make any major changes, these would be noted and passed on to the Constitution Working Group. If appropriate, a report would go to Full Council who were the only body which had the power to amend the constitution. Alternatively, if the changes were minor editorial amendments, these could be agreed by the Director of Law and Governance under delegated authority.

Councillor Luxton noted that there were three Conservative Members appointed to the Board, but they were all Maidenhead based. She asked if there could be a geographically spread of representatives from across the borough. Councillor Luxton also suggested that the People Overview & Scrutiny Panel Chairman should be a Member of the Board.

Kevin McDaniel, Executive Director of People, said that the Housing team had supported the Board and provided many useful updates at meetings. He felt that it would be appropriate for the Head of Housing to have a place on the Board.

Steve Dunn, RBWM Place Convenor NHS Frimley, said that NHS Frimley had been established recently and therefore references to the Clinical Commissioning Group needed to be updated.

RESOLVED UNANIMOUSLY: That the Health & Wellbeing Board approved the changes suggested to the Terms of Reference.

317/15 PRIORITY FOCUS - REDUCING INEQUALITY

Joint Strategic Needs Assessment

Marc Connor, Intelligence and Strategy Officer (Covid-19), gave a presentation on the work of the Joint Strategic Needs Assessment (JSNA). The website had recently been launched and Marc Connor gave the Board a detailed overview of the website, how it worked and what information was available to residents on the JSNA. National inequality trends included:

- Emergency admissions to hospital for under 5s increased as affluency decreased.
- Children from minority ethnic backgrounds underachieved at school.
- Manual workers were twice as likely to smoke.
- People residing in less affluent areas died younger.
- Vaccine uptake was lower in the Polish community.

From Hub data, the white European population was not fairly represented in RBWM. Approximately 3,600 were not vaccinated and of this, two thirds were likely to be Polish. The JSNA contained the tools to identify which areas Polish speakers lived and how the Public Health team could start to consider targeted intervention. The website launch had been communicated to all stakeholders and a general introduction, training and demonstration webinar had been delivered. A public demonstration was also planned for later in the year.

Kevin McDaniel commented that the data which was provided on the website was historical, the pandemic had a big impact. He asked what could be done looking forward and understanding how trends had changed over the past few years.

Marc Connor said that the Public Health team was led by the national data, this research would then inform local thinking. The response from RBWM could be tailored using the JSNA data.

Kevin McDaniel suggested that the Public Health team could influence the future research programme on a national basis to allow RBWM to make strategic decisions going forward.

Councillor Coppinger said that when the first JSNA had been created, he was surprised about the areas of inequality in the borough. The JSNA allowed this information to be shown to the council and parish councils, Councillor Coppinger felt that it was important that Councillors worked closely with GPs.

The Vice Chairman said that the JSNA data had been particularly useful to allow the health service to understand the hidden areas of deprivation.

Councillor Stimson suggested that communication with targeted communities could be more cost effective as a result of the JSNA.

Steve Dunn asked if it was possible to influence the focus of the data in the JSNA. The 2021 census data would be available shortly and could provide some actionable insights, Steve Dunn asked if this was planned.

Marc Connor said that the national data was useful and could be used on different projects at a local level. There were a number of projects that were reliant on the census data, once it had been made available.

Anna Richards, Deputy Director of Public Health for East Berkshire, said the JSNA was a great resource and helped inform commissioning and understanding of the needs of the local population. The JSNA should be used by colleagues, if the Board had any suggestions on how the JSNA could be developed they would be considered.

Introduction to the inequalities programme and emerging themes

Anna Richards outlined the inequalities project to the Board. RBWM was one of the most affluent areas of the country, but there were pockets of deprivation. Over half of neighbourhoods were in the least deprived deciles, no neighbourhoods were in the most deprived deciles but there were some neighbourhoods in some lower deciles. The cost of living crisis meant that the number of families who would be living in deprivation would increase. The main aim of the project was to support all residents and communities to achieve their ambitions and fulfil their potential, with a focus on those who were at risk of poor outcomes. This would therefore reduce demand for high cost services. This aim would be supplemented by three objectives:

- To improve the council's collective understanding of inequalities and disadvantage in the borough.
- To reduce inequalities in the borough, through developing a shared approach, based on evidence.
- To reduce demand on high cost services, through improved prevention and early intervention.

Rebecca Hatch, Head of Strategy, explained that the scope of the project was to consider inequalities in the broadest term and outcomes could be seen across a number of areas. A two phase approach was planned; phase 1 was about understanding the issues and developing an evidence base, phase 2 was focused on developing a shared approach of reducing inequalities. Phase 1 was close to being complete, with most of the data having been collected in an evidence pack. Outputs from the first phase would include the refresh of the Corporate Plan, the development of equality objectives, an evidence base of equality impact assessments and the design of a shared approach to reducing inequalities. This shared approach could include new policies or approaches and the design of more effective strength-based support for communities and families experiencing inequalities. There was also some alignment with other work, for example the Frimley ICS Place and health inequalities work, the JSNA and the Health and Wellbeing Strategy. The methodology for the project would consist of three sources: data analysis, frontline engagement and insights, and community engagement.

Councillor Luxton said that she had been pushing for community engagement to come to the south of the borough but she was not aware of any engagement with the local community that she represented.

Rebecca Hatch said that the world cafes were moving between wards across the borough, she would check with Jesal Dhokia, who was leading the world cafes, and confirm with

Councillor Luxton after the meeting.

ACTION – Rebecca Hatch to confirm the engagement work which was planned for residents in Ascot, Sunningdale and Cheapside.

Kevin McDaniel was interested to see what barriers to health and access to services there were for some families in the borough, he asked if there was any early feedback on clustering.

Rebecca Hatch outlined one key cluster being around financial stress, impact on mental health, impact on relationships and impact on parenting. Another cluster was social isolation, particularly with the elderly age group. Social isolation was also coming through in younger ages groups too.

Kevin McDaniel highlighted that these people were needing support from the public and community sector, the work could be used to see how the council could work better with groups to avoid some of the stresses which many families currently faced.

Councillor Coppinger was pleased to see the progress of the project, he felt that it was long overdue. He appealed to officers to make sure that they involved local Councillors in the project.

Anna Richards confirmed that Councillors had been included in the conversations that had taken place with frontline staff.

Councillor Stimson said that she had attended the world café held in her ward, there had been a huge attendance from local residents. It was a health and wellbeing exercise, understanding how people were coping was key and the engagement was pleasing to see. Councillor Stimson felt that there had been good representation attending the world cafes.

Steve Dunn said that this was an exciting project and had the full support of NHS Frimley. It was well known that residents from the poorer wards of the borough were higher users of health and public services, this underlined the importance of the piece of work and the need for intervention.

Rebecca Hatch said that world cafes had been successful in attracting a wide range of people but there would always be a slight selection basis. There had been focus groups and targeted interviews to ensure that specific groups of people were reached.

Young Carer support in RBWM

Sarah Collin, Family Action Young Carers Project Manager, gave the Board a presentation on the work of Family Action. A young carer was someone under the age of 18 who helped to look after someone in their family who was ill, disabled or misused drugs or alcohol. Research showed that 1 in 5 young people had taken on some form of caring responsibility at home. The UK was rated as advanced internationally, when considering the rights of young carers. It was important to step away from the number of young carers and instead look to understand the prevalence of caring by young people in society and to make sure that they were identified. The pandemic had made unpaid care more visible than before. Emerging research was considering the health and wellbeing of young carers but there was limited research on the long term impact. There needed to be a shift from caring responsibilities to emotional burden of caring and the long term implications. In the UK, approximately 40% of young carers self-reported mental health issues of their own.

Family Action received referrals through a number of different routes and undertook a young carers assessment to understand the situation. It was important that the tasks a young carer was doing were both age and gender appropriate. The impact of caring was also considered

as part of the assessment. Sarah Collin outlined some data on the impact of caring from the past three years in RBWM. Family Action was committed to making sure that caring was a positive experience, they provided a 4-6 month intervention. Families were able to re-refer to the service at any point if there continued to be a support need for a caring role within the family. Considering next steps, it was important that as a society there was a collective responsibility to identify gaps in the service provision. It was also recommended that professionals were educated about the long term impact of care on young carers future mental health.

Sarah Collin concluded by appealing to Members of the Board to identify young carer champions within staff teams, while also identifying suitable referral pathways for young carers.

Berkshire Public Health Annual Report 2021/22

Anna Richards said that each year, the Director of Public Health put together an annual report which could cover a range of topics. This year, the Director of Public Health for East Berkshire had worked in collaboration with the Director of Public Health for West Berkshire to produce a joint annual report. The report had a focus on food: its production, distribution and consumption and what could be done at each stage to reduce its environmental impact.

318/15 UPDATE ON ROUTINE IMMUNISATION PERFORMANCE

Ruchi Baxi, Consultant in Public Health, provided an update on immunisation. There were over 30 programmes which were run by NHS England. Measles was highly infectious and it was therefore important to maintain sustained coverage of 95% to prevent outbreaks. Uptake in RBWM for Measles, Mumps and Rubella (MMR) vaccination had been steadily declining over the past three years. Uptake of the second MMR vaccine had improved from 2017/18 but recent data showed that this increase had plateaued, there had also been a decline in MMR uptake nationally. Work had been undertaken by the immunisation uptake team to collaborate with GP practices across RBWM with a focus on improving the uptake of the second MMR vaccine. A workplan was being developed with Frimley ICS around health inequalities, while there was a national campaign designed to raise awareness of the MMR vaccine, which had been launched in February 2022.

The Human Papilloma Virus (HPV) vaccine helped to protect individuals from being infected by the human papillomavirus. The vaccine had been offered to all pupils in school year 8 since September 2008, since September 2019 it had also been offered to all year 8 boys. Research showed that as a result of the vaccine, there had been an 87% relative reduction in cervical cancer. Comparisons could be made with other Berkshire local authorities.

Ruchi Baxi discussed the flu vaccine and outlined the eligible cohorts who could receive a vaccine. The NHS had worked closely with partners to produce a programme evaluation for 2021/22, to inform delivery and improve uptake. A number of recommendations had been made as part of the evaluation.

Councillor Coppinger asked if there was a link between areas of deprivation and those that had not taken up the offer of a vaccine.

Ruchi Baxi confirmed that there was a pattern at the Thames Valley level, it would be useful to match the data with RBWM on inequalities to triangulate the data.

Councillor Luxton asked if everyone paid for the flu vaccine, or did some cohorts receive the vaccine for free.

She was informed that there were a number of cohorts who were included on the NHS

programme and they were offered the vaccine free of charge. For children, those up to Year 9 were included in the programme. The programme prioritised those who were likely to spread flu in the community or those who could get seriously ill.

Anna Richards highlighted the point that had been made about vaccinations not being considered in isolation from broader health and wellbeing issues. A children and young people's partnership had recently been set up, Anna Richards suggested that this could be connected by the need for vaccinations.

The Vice Chairman encouraged those eligible who had not yet had their flu or Covid vaccine to come along to their local vaccination centre and get it done.

319/15 COVID-19 UPDATE

David Scott, Head of Communities, gave an update to the Board on the Covid-19 situation. Graphs shared showed the number of tests, with a slight increase in positive test rates when the rolling seven day rate was used to assess the latest position. There was a small downward trend on the number of patients which had been admitted to hospital but the health system was still under considerable pressure, in part due to the abstraction of staff with Covid. On vaccinations, there had been a high take up of doses for care home residents and this remained key to ensuring that cases did not rapidly increase.

Steve Dunn asked if there was anything that the Board could do to help the situation.

David Scott said that the underlying messages on vaccinations were the most important, Board Members could help to spread this message and reinforce to the community that vaccinations were essential in helping keep infection levels down.

Councillor Coppinger said that he was aware of someone who had a bad reaction to their third dose of the Moderna vaccine. He asked if this was the only vaccine being offered.

The Vice Chairman confirmed that boosters of Moderna and Pfizer were being offered nationally. However, there was no patient choice available, as vaccine sites could not choose what they were delivered.

320/15 HOUSING UPDATE

Tracy Hendren, Head of Housing, Environmental Health and Trading Standards, said that a briefing note would be shared with the Board along with the minutes of the meeting. High level data was available through the Citizens Portal, with demand for the housing service remaining consistently high across the year. The team was now almost permanently staffed, there were currently 183 live homelessness cases, with a further 99 in temporary accommodation and 153 cases which the team were working through. The cost of living crisis was having a big impact and the team were starting to see some 'homes for Ukraine' schemes breaking down. The Housing Inclusion Team Leader post had recently been filled, who was responsible for the rough sleeper pathway. There were currently 42 people on the pathway, which was ten less than the last update which the Board had considered in July 2022. Work had been in done in collaboration with the RBWM Property Company on refurbishment plans for John West House, the draft plans would be shared with colleagues. There were currently 231 people in temporary accommodation, this was a fairly consistent figure. On Homes for Ukraine, there were currently 143 families in the borough but six of these families were now in temporary accommodation.

ACTION – Mark Beeley to circulate the Housing Update briefing note to Members of the Board with the published minutes.

The Vice Chairman asked Tracy Hendren to pass on his thanks to the team for their work and the great example of partnership working.

321/15 BETTER CARE FUND UPDATE

This item was not considered as officers were waiting for some national data to be received.

Anna Richards mentioned the stop smoking service which had been recently launched.

Charlotte Fox, Public Health Programme Officer, said that the Royal Borough's Stop Smoking Service, Smokefreelife Berkshire, offered a range of options including behavioural support, nicotine replacement therapy and useful self-help digital tools. The service was free for residents of the borough that were over 12 years old. More information was available on the website, www.smokefreelifeberkshire.com, where a self-referral form could also be completed.

322/15 FUTURE MEETING DATES

The next meeting of the Board would take place on Tuesday 24th January 2023 at 3pm.

The meeting, which began at 3.00 pm, ended at 5.10 pm

CHAIRMAN…….

DATE…….....

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Report Title:	**Update on the Pan Berkshire Suicide Prevention Agenda**
Contains Confidential or Exempt Information	**No - Part I**
Cabinet Member:	Cllr Stuart Carroll, Lead Member for Adult Social Care, Children Services and Health
Meeting and Date:	Health and Wellbeing Board 24th January 2023
Responsible Officer(s):	**Prof Tracy Daszkiewicz** **Director of Public Health – Berkshire West** **Dan Devitt Senior PH Strategist – Berkshire West**
Wards affected:	**All**

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REPORT SUMMARY

The Pan Berkshire Suicide Prevention Strategy and associated works aim to support and complement local works on the agenda, all of which contribute directly or indirectly to the following priorities identified in the *Corporate Plan (2021-26)*.

- **Thriving Communities**: Where families and individuals are empowered to achieve their ambitions and fulfil their potential.
- **Inspiring Places**: Supporting the borough's future prosperity and sustainability.
- **A Council trusted to deliver its promises**.

This report is to provide the Royal Borough of Windsor and Maidenhead Health and Wellbeing Board with an update on the Pan Berkshire Suicide Prevention Strategy (the Strategy) and assurance that works are progressing to develop and refine the development of the Strategy and support local action planning and delivery. Alongside this this update presents an update on several central changes, challenges and opportunities flowing from the national Suicide Prevention (SP) Agenda, and the regional and local works under way to address these.

***Trigger Warning**: Given the sensitivity of the issues raised by the SP agenda please note that the following report contains a discussion of deaths from suicide and may be distressing to the reader.*[1]

1. DETAILS OF RECOMMENDATION(S)

RECOMMENDATION: That the Health and Wellbeing Board notes the report and:

i) The Health and Wellbeing Board are requested to note the update provided and discuss the implications for local works flowing from the report and, in particular progress toward refreshing the Strategy

[1] Distressed readers should reach of 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

The Local Data and Trends summary, The Health and Social Care Act 2022 and BOB Integrated Care System, Learning from the Pandemic and the Current Economic Context, The New NICE Guidance NG225, The Pan Berkshire Suicide Prevention Summit, The Cube Model Framework resource and potential Membership of the NPSA. (See section 2 Below)

ii) The Health and Wellbeing Board are requested to accept the following submissions following (See Appendices) on from the Summit referenced in Section 2.

- A summary of outputs from the SP Summit and updated draft of the Strategy
- A Final Strategy and Impact Assessment to come to the Reading Health & Wellbeing board in March/April 2023 for agreement and endorsement (subject to pre-election period)
- A summary of the Cube resource – following later in January 2023
- An outline of potential member and executive officer facing briefing materials for the HWB
- A summary of the NPSA membership advantages and potential local benefits

2. REASON(S) FOR RECOMMENDATION(S) AND OPTIONS CONSIDERED

Options

Table 1: Options arising from this report

- That the Refreshed Pan Berkshire Strategy is considered and progressed via the Reading HWB and other local consultation structures
- That works to re-establish the Local Suicide Prevention partnership continues and is strengthened to capture the ambition for local and regional works and gain wider partner engagement to drive local action
- Outputs from the Suicide Prevention Summit on the 12th December are used to shape and refine the strategy and consultation methodology - Consultation on the Draft Pan Berkshire Strategy commenced at the summit
- A Final Strategy and Impact Assessment to come to the RBWM Health & Wellbeing board in March/April 2023 for agreement and endorsement.

No other option has been considered at this stage given the previous HWB's session (January 2022) support for the Suicide Prevention agenda

2.1 **Context for the Refresh Pan Berkshire Strategy:** In 2012 the government published Preventing Suicide in England: A Cross Government Outcomes Strategy to Save Lives. The strategy recommended that local authorities conduct a suicide audit, produce a suicide prevention action plan, and set up a multiagency suicide prevention group.

2.2 RBWM Health and Wellbeing Board unanimously accepted the Preceding draft of the Pan Berkshire Suicide Prevention Strategy in January 2022. Since its adoption, new data profiles have become available and there is a new policy landscape that has led to a review of the local strategy. This is to consider a greater emphasis on patterns of risk and linked to the focus on health inequalities and the Health & Care Act

2022. This report presents an update on the previously delivered briefing and updated context for suicide prevention at National, Regional, and local levels.

2.3 There are several significant system level changes in NHS Structures and broader contextual challenges that will impact on the SP agenda including the establishment of the NHS BOB Integrated Care System (BOB ICS) in the wake of the NHS Health and Social Care Act 2022(HASC22)[2], the continuing analysis of trends and data as the national SP agenda seeks to understand the impacts of the Pandemic and the country begins to experience the impacts of the "Cost of Living Crises[3]" and a turbulent national economic environment[4] as we approach a winter that will prove challenging to systems, services and individuals alike.[5] The current Suicide Prevention Strategy is in place and has been endorsed by the Health & Wellbeing Board. Since its endorsement, there is a different policy position and greater access to real time surveillance data, necessitating its refresh and review and consultation. This report presents an update on works to date and to follow.

2.4 **UPDATE**

Following on from agreement at the January 2022 RBWM Health and Wellbeing Board to agree the 2021 version of the strategy discussions with Berkshire system partners to agree an the approach to refreshing the Strategy. Central to suggested refresh have been several key developments in the evolution of the National, Regional and Local postures to suicide prevention with implications for policy, operational delivery, and data intelligence environment**.**

2.5 **Local Data Intelligence Summary 2021 to 2022:** Please find below a concise summary of Suicide related data to date. It is crucial to note that each number represents an individual tragedy and wider impacts across families and communities.

2.6 **Pan Berkshire and RBWM Suicide data**

2.7 **Office for National Statistics (ONS) and OHID Data**

2.8 ONS reports that 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.

2.9 Since 2001, 103, 610 completed suicides have been recorded in England and Wales. In the same period 1,295 completed suicides were recorded in Berkshire, of which 203 were recorded in RBWM, with 100 of these completed suicides recorded between 2012 and 2021.

2.10 The OHID Suicide Prevention Profile shows that between 2019 and 2021 there were 31 completed suicides in RBWM with (24 male and 7 female). This showed a rate of 8.2 deaths per 100, 000 in comparison with the regional rate of 10.6 deaths per 100, 000.

2.11 **Real Time Suspected Suicide (RTSS) Data –** This collects data on apparent suicides and is subject to clarification and conformation or refute by coronial and

[2] Health and Care Act 2022 (legislation.gov.uk)
[3] Rising living costs: The impact on NHS, staff and patients (nhsproviders.org)
[4] Chancellor Statement - 17 October - GOV.UK (www.gov.uk)
[5] NHS England » Winter resilience

or other processes but provides an essential local intelligence snapshot. It records by place of death as part of an evolving national network of RTSS works aimed at capturing details of apparent suicides in support of cross border working. RTSS data includes apparent suicides and is not restricted – as with OHID and ONS data feeds - to completed suicides as a category arising from coronial proceedings and conclusions. RTSS data is recorded by the location of the reported fatality and will in the course of business include deceased persons who were when they lived resident in other areas, whilst Coronial proceedings usually restrict themselves to the deceased's usual place of residence.

- In 2021 there were a total of 63 deaths by suicide in all of Berkshire. Of these deaths 37 were male and 26 were female showed
- So far in 2022 there have been 66 deaths across Berkshire.
- Of these deaths 48 were males and 18 were females.

2.12 **RTSS Trends for Pan Berkshire Deaths**

Year	Total	Female	Male	YTD/Whole Year
2022	66	18	48	YTD
2021	63	26	37	Whole Year
2020	62	24	38	Whole Year
2019	66	16	50	Whole Year
2018	62	16	46	Whole Year
2017	60	13	47	Whole Year

RTSS Data 2017 to 2022 Whole year or Year to Date

2.9 Royal Borough of Windsor and Maidenhead (RBWM) RTSS data

- Between 2019 and 2021 there were 49 deaths by suicide in RBWM – Gender breakdown shows 35 male and 14 female deaths
- So far in 2022 there have been 16 deaths by suicide in RBWM. Gender breakdown of these has been suppressed.[6]

Methods of Suicide in Berkshire:

- Ligature (hanging) remains the most common method of suicide across Berkshire, accounting for more than half the deaths across the county. Other common methods include the railway (either jumping in front of a train or from a bridge) and overdose.
- In 2022 there has been an increase in the numbers of deaths on the railway, particularly in Slough and Windsor & Maidenhead. Appropriate measures have been taken in these areas in order to review and create actions moving forward. This method of suicide will be monitored closely across Berkshire and appropriate measures will be put in place if an increase is seen in other areas.

[6] It is usual practice to suppress details of any group, characteristic or occurrence where the number drops below 5 to avoid the potential of deductive identification

- A recent and emerging concern centres on the use of Sodium nitrate and nitrite related deaths in Berkshire in 2022 ("**Number suppressed"** compared to zero in 2021). Since this has been raised at the Berkshire Suicide Prevention Group meeting action has been initiated in order to explore this in more detail an ascertain local, regional, and national trends.
- Further works focussing on high frequency locations - car parks and the rail estate has been identified as a priority for the Pan Berkshire Partnership to address in 2023.

2.13 **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 been **Number Suppressed** 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 those reported in 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 currently 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 and other core vulnerable groups and high frequency and high risk locations.
- Further works are anticipated as refinement of the proposed new structure for the partnership and agreement of the refreshed strategy unfolds in 2023.

2.14 **The HASC22 and BOB ICS** 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 has been 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 shared. 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. The cross-border nature of the SP agenda[7] – 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[8]" support and widened availability of

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

[8] Support following on from a completed suicide to address the impact of traumatic death on loved ones and close contacts in an education setting, workplace, or community, who require a specific range of support to ensure that they do not go on to

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

2.15 **Learning from the Pandemic and the current Economic Context:** The National Confidential Enquiry into Suicide and Safety in Mental Health (NCISH) [9] is the Manchester University SP surveillance and prevention "observatory" commissioned by the NHS via the Healthcare Quality Improvement Partnership.[10] 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.[11]

2.16 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 [12], 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"*[13]. 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 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.

2.17 **National Institute for Health and Care Excellence (NICE) NG225:** In September 2022 NICE published Nice Guidance 225 covering Self Harm across all ages.[14] 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

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experience significantly poorer mental health outcomes than might accompany a bereavement that was anticipated due to an end-of-life condition or advanced older age,

[9] NCISH | The University of Manchester

[10] HQIP – Healthcare Quality Improvement Partnership

[11] 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

[12] Essentially rate is the number of deaths per 100k of population in any given area for a set period of time.

[13] NICISH Lancet ibid.– see Discussion

[14] Overview | Self-harm: assessment, management and preventing recurrence | Guidance | NICE

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.

2.18 The Pan Berkshire Suicide Prevention Summit: Following on from the July 2022 HWB meeting a Pan Berkshire Suicide Prevention Summit was held on the **12th of December 2022**[15]. The Summit presented overviews of the National, Regional and Local context, an update on Pan Berkshire Works to date, data intelligence and service delivery insights, and the view of priorities and possible next steps for the strategy. The refreshed Strategy was shared in outline form and discussed with attendees, as an initial engagement and consultation exercise to ensure the Strategy is shared and developed in partnership with all Berkshire place-based system leadership and benefits from their insight and steer. (See Appendix A and B)

2.19 A key element of the Summit's discussion focussed on what works need to be progressed at regional and local or place-based scale and how we can learn from best practice across a variety of agenda areas ranging from infrastructure focussed works (making bridges and other key parts of the built environment in local area where suicide is a risk or sadly historic feature as safe as possible) to positive mental health and wellbeing support for Children and Young People and neurodiverse groups. The Summit sought to gain an understanding of what the key outputs from the Pan Berkshire works should be through a session devoted to understanding the wide range of support needs that system partners and place-based leadership might wish to see prioritised. Despite technical issues with break out rooms on the day there are a number of key outputs from the session –and a range of additional engagement opportunities will run from late January to March 2023. (See Appendix A)

2.20 Other outputs included Training and Development for the statutory and Voluntary and community sector workforce alongside specific works targeting self-harm and suicide prevention awareness across all or particular age ranges and vulnerable groups including minoritised communities, LGBTQ plus people, Elected Member awareness briefings and localised resource packs and aligned communications to share awareness and ensure impactful public and professional facing messaging in line with the Strategy and wider works.(See Appendix A and Appendix D)

2.21 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"**

[15] Invitations to the Summit are being extended to all Elected Members and the Executives and Senior Leadership of all Berkshire Local authorities, System Partners and Operational leadership.

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[16], etc.**

2.22 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.

2.23 It is not a clinical resource for specialist colleagues working within mental health services or systems, aiming instead to provide a wide range of general information that can help the wider both public and wider system professionals who are looking for support. The Cube was initially circulated in draft form in July and a revised version for consultation and sign off will be shared at the Summit. Discussions are underway about the best way to ensure that the resources contained within the Cube are available to both public and professional audiences, with Frimley ICS agreeing to host the resource and discussions commencing with BOB ICS to ensure availability across the neighbouring footprint.

2.24 **Commissioning of Amparo:** Amparo a specialist suicide post-vention support service, part of the Listening Ear group of counselling services has been commissioned to deliver services from 1st July 2022, covering Berkshire West, East, Oxfordshire and Buckinghamshire as the commissioned bereavement support provider for the patch. The initial contract is for two years to 2024.

2.25 **Office for National Statistics (ONS) Data release**[17] the last significant release of date from ONS was published in 2019, and it is anticipated that ONS will publish a refreshed assessment and summary of prevalence incorporating 2021 census data and population specific details at some point in 2023.

2.26 **Health In All Policies and National Suicide Prevention Alliance**[18]- (NSPA) Membership: - There are potential benefits for local pace based systems by applying for membership of the National Suicide Prevention Alliance and seeking to ensure that local Health in All Policies works are supported by ensuring that self-harm and suicide prevention and wider physical and mental health related issues are prioritised at a corporate level and this flows into procurement, commissioning and communications works. Signing up for NPSA membership can be a clear signal of local corporate commitment across the business, statutory and voluntary and community sector. Currently there is no published membership from any Reading based organisation. If the HWB were keen to augment local works then the Council could itself sign up as a member and begin to progress SP related works across its network and systems in the local area (See Appendix E).

[16] LEDER - the NHS Learning Disability Mortality Review
[17] Suicides in the UK - Office for National Statistics (ons.gov.uk)
[18] About Us - NSPA

3. KEY IMPLICATIONS

Engaging with the revised and updates Pan Berkshire Strategy will enable RBWM SP works to link in to the refreshed Pan Berkshire workstreams and support offers flowing from the revised strategy.

Table 1: Key Implications

Outcome	Unmet	**Met**	**Exceeded**	**Significantly Exceeded**	**Date of delivery**
Alignment and local insight contributed to steer the draft Pan Berkshire Strategy and SP agenda	TBC	TBC	TBC	TBC	Circa March/April 2023 depending on end date for the Pan Berkshire consultation which is currently tbc.

3.1 Given the complexity of consulting across six Berkshire local authorities and the sensitivity of managing public consultation on the theme of suicide prevention the timescales involved are imprecise. It is anticipated that the professional consultation phase will be completed by March or April 2023. Currently an approach for public consultation is being assessed to ensure that the consultation is sensitive to a wide range of community experiences, needs and sensitivities across the six Berkshire local authority areas.

4. FINANCIAL DETAILS / VALUE FOR MONEY

Currently Suicide Prevention is a noted public health priority, there is no current allocation of the Public Health Grant specifically to deliver this programme of work outside of officer capacity. The Pan Berkshire Partnership does not currently have any budget assigned to it and the secretariat functions that support it are paid for through contributions received solely from Berkshire West based authorities that support the public Health Hub which supports the Partnership with officer capacity.

LEGAL IMPLICATIONS

4.1 There are no legal implications arising from this report.

5. RISK MANAGEMENT

There are no current risks identified with engagement with the refreshed Pan Berkshire Strategy. This will be reviewed on an ongoing basis.

6. POTENTIAL IMPACTS

6.1 Equalities. An Equality Impact Assessment was completed in Jan 2022 is available as Appendix B to the January 2022 Suicide Prevention Report to the Health and Wellbeing Board. A new EIA in line with the refreshed strategy is

under preparation and will follow in line with the strategy as it is refined throughout the consultation.

6.2 Currently the strategy has no Climate change/sustainability implications. With the emphasis on the Pan Berkshire Strategy on “no budget” delivery there will be an avoidance of consumption of resources outside of the online environment and an avoidance of travel requirements and its associated carbon footprint throughout the consultation period and the life of the strategy. Local works will continue to factor in Climate change/sustainability implications in support of RBWM corporate objectives.

6.3 Data Protection/GDPR. The Strategy itself does not require any specific Data Protection/GDPR response, though aligned works flowing from Thames Valley Police Real Time Suspected Suicide Surveillance which will require continual review. (See TVP RTSS Resource Pack for an overview of the RTSS workstream.)

6.4 Overall Suicide Prevention sits under and adheres to the provisions set out in HM Government’s national Consensus Statement Information sharing and suicide prevention: consensus statement - GOV.UK (www.gov.uk). In general terms sensitive proportionate and secure sharing of information to prevent a suicide attempt opr learn from a completed suicide is explicitly required by the Government provision and there is a duty of co-operation on statutory agencies to collaborate in these twin areas of Suicide Prevention.

6.5 In general terms the Data protection Act does not apply to deceased persons, though there are clear issues of prior consent, capacity and the necessary sensitivity and consultation with surviving relations of the deceased. Furthermore Recital 27 of the GDPR says "This Regulation does not apply to the personal data of deceased persons. Member States may provide for rules regarding the processing of personal data of deceased persons." The information about a deceased testator held by personal representatives and those acting for them will not be subject to GDPR obligations. See Principles of consent: Deceased people - Consent and Participant information sheet preparation guidance. (hra-decisiontools.org.uk) for an overview of the practical implications of death and Data Protection and GDPR.

7. CONSULTATION

7.1 As referenced above a professional facing consultation commenced in December 2022 with the publication of the draft strategy at the Suicide Prevention Summit. The Pan Berkshire Partnership will undertake public consultation under Section 138 of the Local Government and Public Involvement in Health Act 2007. Both consultations are currently likely to end in March to April 2023 depending on the pace and completeness of inputs received from the six Berkshire Local Authorities.

8. TIMETABLE FOR IMPLEMENTATION

8.1 **Implementation date if not called in:** The strategy is under consultation to March or April 2023 and may be extended depending on the range and completeness of contributions received. Sign off by the six Berkshire local

Authorities Health and Wellbeing Board is a central requirement and the timescales and scheduling of initial consultations and approval by each Local authority is underway. Once agreed the Strategy will be for Five Years with annual refresh in consultation with Pan Berkshire Partnership member organisations in line with developments at National, Regional Pan Berkshire and Local level.

Table 2: Implementation timetable

Date	Details
December 2022	Publication of Draft Strategy and consultation at the Pan Berkshire SP Prevention Summit (12th December)
	Socialising of key concepts and sharing of Drafts with Berkshire system and request to present to each Berkshire HWB
Jan to March 2023	Public consultation launch – late Jan 2023 Further professional engagement events Published – See Appendix X Requests made to all Berkshire Health and Wellbeing Boards

9. APPENDICES

9.1 This report is supported by **five** appendices:

- Appendix A Summary of outputs from the SP Summit
- Appendix B Consultation draft of the Pan Berkshire Strategy
- Appendix C Summary of the Cube resource and consultation copy for review
- Appendix D Outline of potential member and executive officer facing briefing materials
- Appendix E Summary of the NPSA membership advantages and potential local benefits

10. BACKGROUND DOCUMENTS

10.1 This report is supported by two background documents:

- The Existing EIA set out as appendix B to the January 2022 Suicide Prevention Report to the Health and Wellbeing Board (NB a refreshed EIA at Pan Berkshire level is currently being drafted and will be informed and completed as the consultation on the draft strategy proceeds.)
- The National Suicide Prevention Strategy 2012 and subsequent annual reports and refresh

11. CONSULTATION

The Strategy and Report have been discussed and shared with all Pan Berkshire Suicide Prevention Partnership members (including RBWM Public health personnel) alongside direct communications to all health and Wellbeing Boards and Public Health teams in the Berkshire area to present the refreshed strategy to them and seek their input into its refinement and agreement.

Further consultation is planned as set out above and further suggestions for consultation opportunities is sought.

12. REPORT HISTORY

Decision type:	**Urgency item?**	**To follow item?**
Report to the Health and Wellbeing Board	No	No

Report Author: Daniel Devitt Senior Public Health Strategist Berkshire West Public Health Hub Professor Tracy Daszkiewicz Director of Public Health for Berkshire West and Chair of the Pan Berkshire Suicide Prevention Partnership

Appendix A Summary of outputs from the Suicide Prevention (SP) Summit

1 Context for the Summary:

In the run up to the Pan Berkshire Suicide Prevention Summit on the 15th December 2022 and subsequently a range of inputs and outputs were identified. Partly this flowed from a survey conducted prior to the summit, with much additional content being contributed on the day.

2 Additional Engagement sessions

A key element of the Summit was curtailed when online break out rooms failed to function and, in their stead, a general point by point discussion was held with the attendees.

Whilst this was very helpful in capturing concerns and ideas it may be the case that some participants did not feel confident in contributing to the wider group discussion when a smaller working group environment would have been more conducive to their participation and engagement.

Given the technical challenges on the day a range of additional online opportunities to engage and shape the emerging Pan Berkshire Strategy are being offered to professional stakeholders and system leaders from January through the March 2023.

- Thursday 26th January from 15.00 to 16.00 Click here to join the meeting
- Thursday 2nd February from 12.00 – to 13.00 Click here to join the meeting
- Thursday 23rd February from 1730 to 18.30 Click here to join the meeting
- March 1st from 12.00 to 13.00 Click here to join the meeting
- March 16th from 12.00 to 13.00 Click here to join the meeting

In person events are being considered alongside these if Berkshire authorities, system partners and groups in local areas request them.

3 Feedback Surveys:

Additional feedback on the Summit and its outputs are being sought via two separate surveys –

- The Summit Evaluation Survey Link to evaluation survey
- The Draft Strategy Consultation Survey Link to consultation survey

4 The Outputs from the Summit

Prior to and during the summit there were clear consistent messages of support for the aims of both the Summit (to focus on Suicide Prevention in Berkshire and begin a conversation on the Strategy) and the draft strategy itself.

Specific support requests aired at the summit – despite the technical issues mentioned above- have helped confirm the overall direction of travel for the Pan Berkshire SP works.

- Reasserted value of Pan Berkshire Partnership –
- The Summit delivered and Initial Positive response to:
  - reforming the structure for the Partnership
  - High level outline of the Strategy and likely items/focus for the workplan
  - Suggested outline and balance of National/Regional/Local works

- Prevention Concordat/Suicide Specific Pledge for Pan Berkshire Works
- Strong messages re Diversity and Inclusion – SP must be for **all groups and communities/characteristics** and **local area priorities**

5 Calls for support

In addition to the inputs from the Summit preliminary mapping of calls for support from local system partners across local authorities, the NHS and Voluntary and Community Sector partners have included calls for additional support from a Pan Berkshire level for:

- Support for Local Action Planning
- Whole-systems approach to Suicide Prevention
- CYP facing works
- Communications and Training and Evidence based approaches to SH and SP
- Systematic approaches to post vention in the community
- RTSS Data and insights and actioning works that flow from it
- Domestic Abuse (incl adolescents) – mental health understanding & responses; routine enquiry
- Bite size learning sessions to upskill practitioners to support 'lower level' mental health needs whilst awaiting referrals / access to mental health services (particularly CAMHS)
- Links with local CSPs and other groups
- Consideration of impact on all family members
- Reflective practice sessions to share understanding access expert input
- Cost of living – Including CYP
- Providing Naloxone and related training to Thames Valley Police

These calls for support, alongside the insights and ideas that are gathered via the consultation surveys and engagement opportunities will inform the key areas of delivery and support provided by the Pan Berkshire Partnership and help shape and agree the focus alongside the works underway with Berkshire Health and Wellbeing Boards to finalise and agree the pan Berkshire Suicide Prevention Strategy.

Appendix B

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

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

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

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.

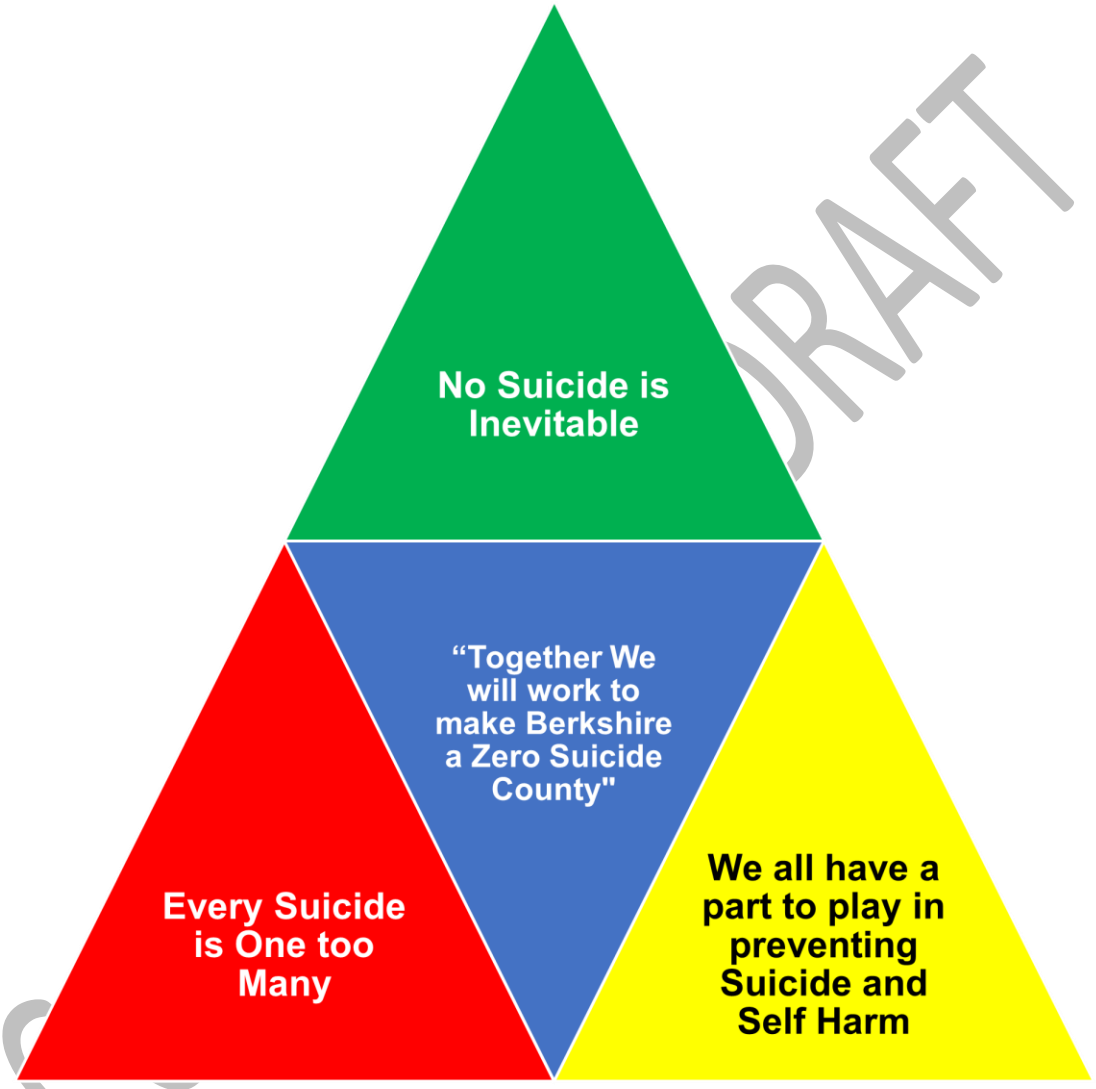


Fig 1 The Vision and Key Principles for the Pan Berkshire Strategy

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 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

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

	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

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.

[5] Marmot Review report – 'Fair Society, Healthy Lives | Local Government Association
[6] Suicide Prevention Profile - OHID (phe.org.uk)
[7] Suicides in England and Wales - Office for National Statistics (ons.gov.uk)

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.

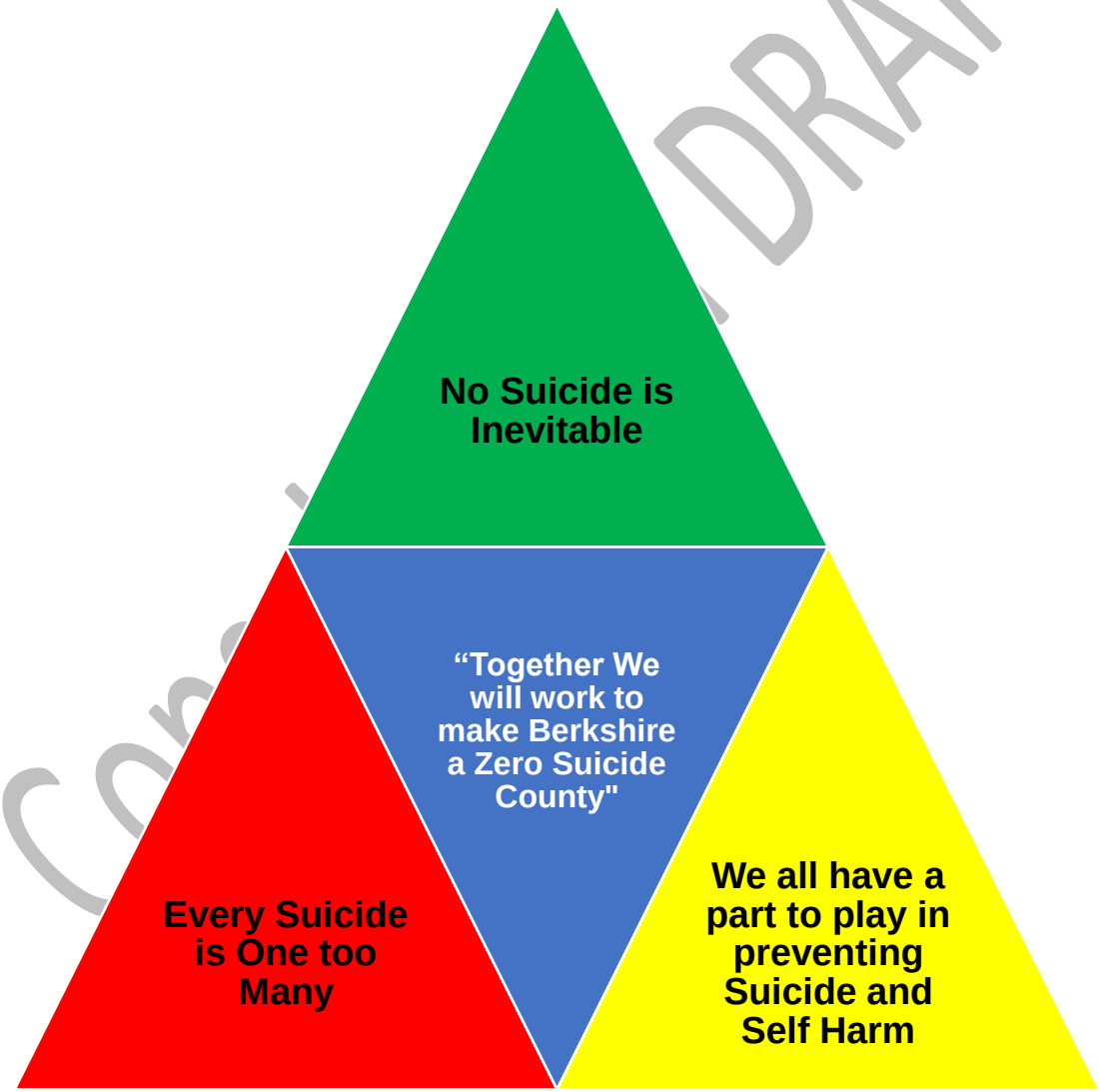
By initiating conversation, enhancing awareness, providing support, and directing help to those who need it, we can reach out to support those who are self-harming, and we can all help prevent suicides and help save lives.

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.

10 Towards Zero Suicide -

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

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 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

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

	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.

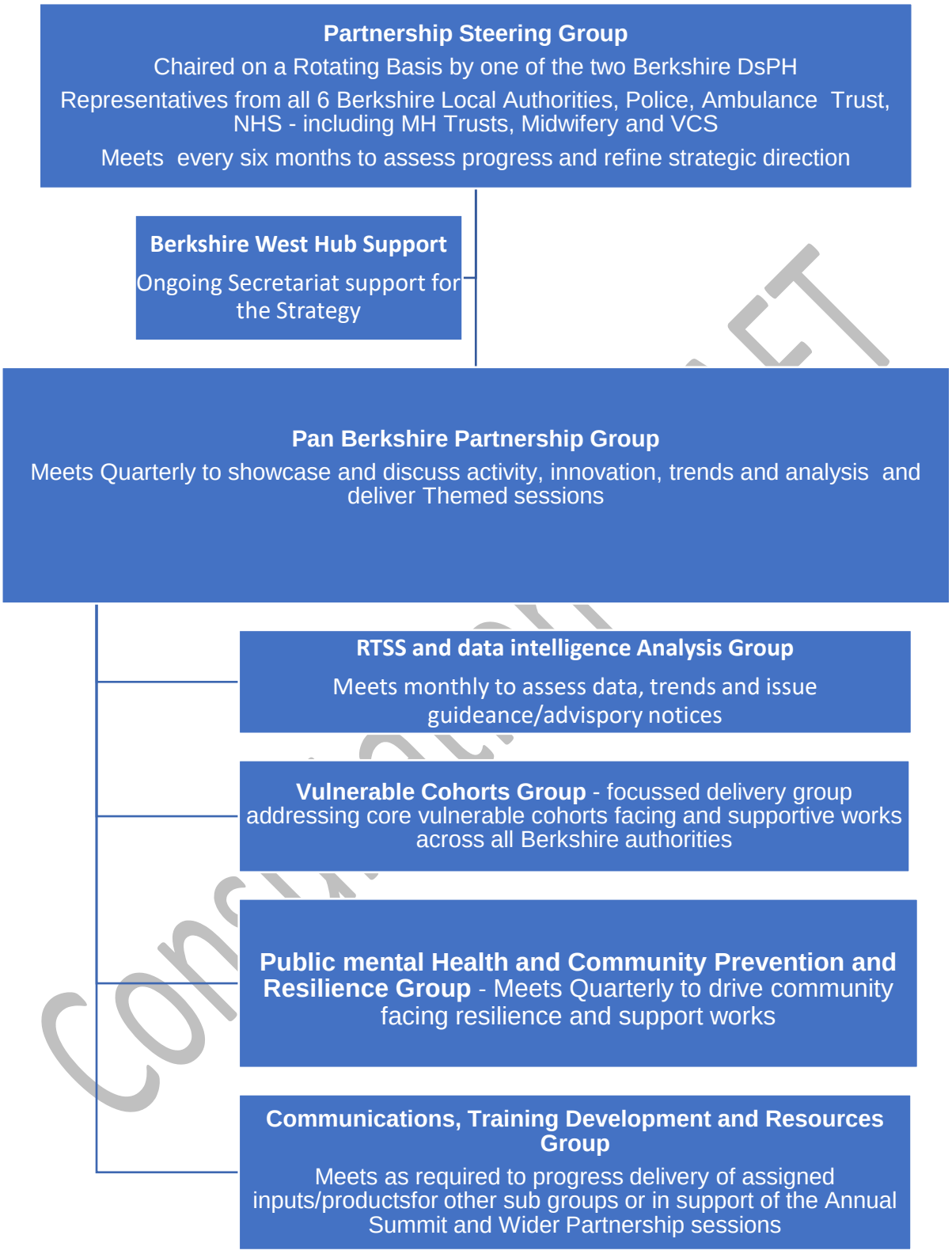


Fig 3 Proposed restructured Pan Berkshire Partnership

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 disproportionately 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 multidisciplinary 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

[11] ibid

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.

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 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

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

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 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.

[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

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 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

[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)

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:

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**

[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)

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-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).

[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

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 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

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

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

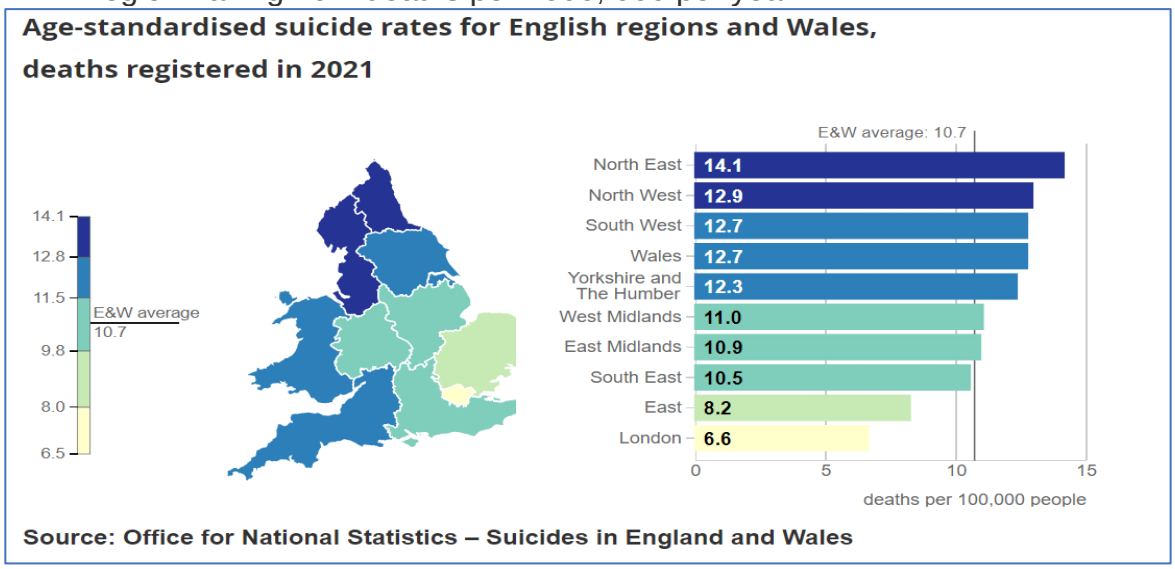


Fig x ONS analysis of the Suicide rate per 100, 000 by region 2022[35]

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.

[35] Suicides in England and Wales - Office for National Statistics (ons.gov.uk)
[36] Guide to coroner services - GOV.UK (www.gov.uk)

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

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.

[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)

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.

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

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

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.

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

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
- 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.

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:

[43] LEDER - the NHS Learning Disability Mortality Review

- 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 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.

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

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

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

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Gwen Wild - The Coroners' Courts Support Service

Hazel Walsh Atkins - Wokingham Sobs

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Meradin Peachey - Director of Public Health for Berkshire West.

Appendix B: Recommendations from the 2021 Draft Strategy

The following are recommendations for this strategy, which will inform the Berkshire wide action plan for 2022 to 2027.

Overarching recommendations:

1a) To continue to monitor the impact of COVID-19 on suicide across the lifecourse through RTSS data and respond to any identified trends.

1b) To continue to monitor the wider trends emerging from the impact of COVID-19 on people's mental health and suicide risk across the lifecourse, and to support the system to take action where required.

1c) To undertake a Berkshire suicide audit.

1d) Undertake regular reviews of information, resources and channels for people affected by suicide.

1e) Hold an annual multi-agency conference on a range of topics to share information and best practice and raise awareness to the risks for suicide.

1f) Invite additional partners across the System within Berkshire, including the voluntary and community sector to join the Suicide Prevention Group for improved cross-topic working.

1g) Set up sub-groups of the Suicide Prevention Group, informed by local intelligence and data, where there is a need to focus upon a risk factor or group within the population.

Priority area 1: Children and Young People

2a) To raise awareness of the link between trauma and adversity, and suicide across the life-course.

2b) Continued investment into the Be Well campaign to encourage the importance of looking after emotional wellbeing, in addition to signposting to local mental health services and support in order to prevent self-harm and suicide in children, young people, and women.

2c) Support the system to adopt a needs-led approach for neurodiverse children and young people, particularly in the prevention and early intervention arena, e.g. in schools and the community.

2d) To explore improving data capture on sexual orientation for all ages in RTSS data and promote this across the suicide prevention system.

2e) To work with local organisations and charities who work with the LGTBQ+ community on suicide prevention.

2f) To raise awareness of the impact of the transitional period (children moving into adulthood) on the mental health impact and the risks of suicide during this period for children and young people.

2g) To link with the work across the BOB and Frimley ICS on the ease of access to shared care records across system partners for transition population (children moving into adulthood).

2h) To support higher education establishments within Berkshire, including universities to adopt a needs-led approach to neurodiversity.

Priority area 2: Self-harm

3a) Decrease the stigma related to self-harm and encourage help seeking behaviour and self-care.

3b) Help friends, family and professionals understand the physical and emotional signs of self-harm, how they can help and where they can get support.

3c) Explore the impact of self-harm on parents and siblings on their own mental health and wellbeing.

3d) Regularly review local intelligence and data on self-harm at the Berkshire Suicide Prevention Steering Group, ensuring additional relevant data from a wide range of sources are included (e.g. development

of RTSS to include self-harm, ambulance service data, primary care and schools).

3e) Working with Mental Health Support Teams (MHSTs), ensure a continued focus on the prevention of self-harm by increasing resilience and general coping skills and support for those who self-harm.

Priority area 3: Female Suicide

4a) Link with the BOB and Frimley local maternity systems on suicide risks in the perinatal period.

4b) To explore data collection on the perinatal period; risk factors and the link to suicide including data captured in the RTSS.

4c) Promote the need for clear pathways and knowledge exchange between domestic abuse and mental health services.

4d) Improve data collection of domestic abuse data in RTSS.

4e) Include domestic abuse indicators in the Berkshire suicide audit to better understand the link between domestic abuse and suicide.

4f) Provide information to domestic abuse services on how to respond to concerns where clients may be self-harming or considering suicide (whether the client is a victim, survivor, perpetrator or child or young person).

4g) Raise awareness of the information, resources and services available for parents and carers who are experiencing stress, through inputting into local campaigns.

Priority area 4: Economic Factors

5a) Work with colleagues to raise awareness of the risk between debt, mental health and suicide risk among frontline professionals and the wider public. Awareness raising needs to;

- reduce the stigma of 'being in debt' and signpost to access debt and benefit advice and support. this information also needs to be shared with frontline professionals
- encourage people in debt to reach out for help to reduce impact on mental health
- encourage people with poor mental health to reach out for debt advice

5b) Support frontline professionals to feel comfortable about talking about debt and financial problems and the link to poor mental health and suicide risk and what support is available.

5c) Support Berkshire local authorities with a single point of access information site around money matters.

5d) Ensure compassionate debt collection. Make sure the process is supportive and aims to steer residents to places that can provide help and support. Support vulnerable groups at increased risk of debt including people with long-term conditions or disabilities.

5e) Work with key partners to actively promote services that provide help around navigating the benefits system and potentially increasing people's incomes.

5f) Make sure that all parts of the health service where patients showing suicidal intent first make contact, are signposted or triaged appropriately using a process that includes debts and other economic stresses as risk factors.

5g) Work with system partners on the early identification and support of people who are at increased risk of debt and financial concerns (e.g. unemployed or people with long-term conditions) as early as possible and offer effective support to manage personal finances through appropriate referral pathways.

5h) Monitor local data and intelligence on levels of problem gambling within Berkshire and its link to suicide.

Priority area 5: Bereaved by suicide

6a) Ensure our local bereavement offer is culturally and ethnically appropriate for different groups within communities to develop resources and services.

6b) Continued support to the volunteer led local SoBS groups to be able to continue to offer a peer-to-peer support service.

6c) Building in bereavement support to extend to wider family members, friends and communities.

6d) Continue to commission suicide bereavement support services and monitor its impact.

6e) Explore training opportunities for colleagues and workplaces impacted by suicide.

6f) Work with Thames Valley Police and other first responders to a suicide, to share appropriate resources with employers.

Appendix C 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** 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. These according to the ONS[1] and other national and local data sources include:

Cohort	Outline of the Issues
Children and Young People	The Royal College of Paediatricians and Child Health's 2020 report into the State of Child Health notes that suicide in children and young people may be associated with many factors, including poor mental health; self-harm; academic pressures or worries; bullying; social isolation; family environment and bereavement; relationship problems; substance misuse; or neglect[2]. Adverse childhood experiences, stressors in early life and recent events also contribute to the risk[3]. Good mental health and emotional wellbeing in children and young people can help build resilience, and in turn become a protective factor against suicide. The NHS five-year forward view recognises that children and young people are a priority group for mental health promotion and prevention. Early intervention and quick access to good quality care is vital – especially for children and young people. Waiting times should be substantially reduced, significant inequalities in access should be addressed and support should be offered while people are waiting for care[4]. The NCISH 2017 report on suicide by children and young people highlighted themes that should be specifically targeted for prevention[5]; • Support and management of family factors like mental illness or substance misuse • Childhood abuse • Bullying • Physical health • Mental ill health • Alcohol or drug misuse Groups highlighted to be at increased risk of death from suicide included young people who are bereaved, students, looked after children, young people who identify as LGBT. Previous self-

[11] Suicides in England and Wales - Office for National Statistics (ons.gov.uk)

[2] Royal College of Paediatrics and Child Health (2020) *State of Child Health*. London: RCPCH. Available at: stateofchildhealth.rcpch.ac.uk Last accessed 10/08/21

[3] Samaritans (2019) Suicide Statistics Report – Latest statistics from the UK and Northern Ireland. Surrey: Samaritans. Available at SamaritansSuicideStatsReport_2019_Full_report.pdf Last accessed 10/08/21

[4] NHS Five Year Forward View. NHS (2014). Available Five Year Forward View (england.nhs.uk) Last accessed 02/09/21

[5] NCISH Suicide in Children and Young People. NCISH (2017) Available NCISH | Suicide by children and young people in England - NCISH (manchester.ac.uk) Last accessed 12/08/21

	harm was a crucial indicator of risk with around half of young people who had died by suicide having previously self-harmed. Transition across all stages of life but especially that from childhood to adulthood (aged 16-25) is often characterised by changes and adjustments and challenges, particularly around increasing independence and responsibility, and developing self-esteem. During this period, young people may also transition with regards to their physical and mental health services including transition from children's mental health services to adult mental health services. It is crucial that transition is managed carefully and effectively so that early and effective support is accessed.

Men	Men are by far the largest group in terms of suicides and account for some 70% of the national total 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, while among males it was highest in those aged 50 to 54 years (22.7 deaths per 100,000). Looking at trends over time in broad age groups, males aged 10 to 24 years have had the lowest rates since 1981. In 2021, the rate in this group was 8.0 deaths per 100,000. Since 2010, men aged 45 to 64 years have had the highest age-specific suicide rates. In 2021, the rate in this group was 20.1 deaths per 100,000. Males aged 25 to 44 years had the highest suicide rates between 1995 and 2009, whereas males aged 75 years and above had the highest rates at the beginning of our series between 1981 and 1991. Male rates for all age groups were higher in 2021 than in 2020, except for those aged 75 years and over where the rate remained unchanged.
Women	Within England and Wales, there has been a growing increase in female deaths by suicide. In 2019, the suicide rate among females and girls was 5.3 deaths per 100,000, up from 5.0 in 2018 and the highest since 2004[6] Risk and protective factors for suicide can affect men and women differently, therefore understanding the relationship between gender and these risk factors is of importance for effective suicide prevention. For example, risk factors such as domestic abuse disproportionally affect women[7] The perinatal period refers to pregnancy and the first year following the birth of a child. Perinatal mental health problems are mental health problems that occur during this period. They affect up to 20% of new and expectant mothers and include a wide

[6] Suicide rates continue to rise in England and Wales. *BMJ* 2020; Available: https://doi.org/10.1136/bmj.m3431 Last accessed 08/08/21

[7] [2] Samaritans research briefing: Gender and Suicide (2021). Available ResearchBriefingGenderSuicide_2021_v7.pdf (samaritans.org) Last accessed 08/08/21

	range of conditions including depression, anxiety, and psychosis. If left untreated, perinatal mental health issues can have significant and long-lasting impacts on the woman, the child, and the wider family. The latest confidential enquiry into maternal deaths in the UK and Ireland (2019) found that suicide is the second largest cause of direct deaths in mothers occurring during or within the 42 days at the end of pregnancy[8]. Research has shown that in some mental disorders, such as postnatal depression, bipolar disorder and postnatal psychosis, there is an increased risk of suicidal ideation, suicidal attempt, or suicide[9]Prevalence of mental illness varies by maternal age, with many studies finding a significant correlation between young age and depression or anxiety during pregnancy. Some studies have also found high rates of mental illness amongst older mothers[10]. Agencies across the maternity system involved in the care of expectant and new mothers must carefully monitor and early identify suicide risk and potential risk factors, to reduce suicide risk within this group. Among females, the age-specific suicide rate was highest in those aged 45 to 49 years (7.8 deaths per 100,000 The rate for females was 5.5 deaths per 100,000. Females aged 24 years or under have seen the largest increase in the suicide rate since ONS began to look at suicide rates in 1981. RTSS data from 2020 had highlighted an increase in the proportion of all suicides which are female suicides from 21% in 2017 to 39% in 2020. Female suicides have shown a small but steady increase from 13 in 2017 to 24 in 2020. In 2021 The Berkshire Suicide Prevention Group formed a sub-group to carry out a deep-dive review based on RTSS (GEN-19) data supplied by the TVP and further supplemented by further enquiries of GP practices, secondary mental health care (particularly Serious Incident Review findings), and of bereaved families and a specialist postvention service. Across the period January 2020 to May 2021, female deaths were highest in Slough and Reading of the six Berkshire unitary areas, accounting for 26% and 37% of all female deaths respectively.

[8] Saving lives, improving mothers' care 2019 report (2019) Available MBRRACE-UK Maternal Report 2019 - WEB VERSION.pdf (ox.ac.uk). Last accessed 02/09/21

[9] Orsolini, Laura et al. "Suicide during Perinatal Period: Epidemiology, Risk Factors, and Clinical Correlates." *Frontiers in psychiatry* vol. 7 138. 12 Aug. 2016, doi:10.3389/fpsyt.2016.00138

[10] Biaggi A, Conroy S, Pawlby S, Pariante CM. Identifying the women at risk of antenatal anxiety and depression: A systematic review. J Affect Disord. 2016 Feb;191:62-77. doi: 10.1016/j.jad.2015.11.014. Epub 2015 Nov 18. PMID: 26650969; PMCID: PMC4879174.

	Children witness to or living in a household where domestic abuse is present is a highly traumatic experience and can lead to lasting harms and risk-taking behaviours throughout the lifecourse. Perpetrators are also at risk of suicide, where the perpetrator is currently under investigation, or is being convicted of the abuse. It is clear therefore, that domestic abuse has a profound impact for those experiencing, witnessing and perpetrating, increasing risk immediately, and throughout the life course. Up until the age of 60, there is an increasing trend in the number of suicides by age. When considering 10-year age bands, deaths are highest in the 40-49- and 50–59-year-old age groups, with these two groups accounting for 49% of deaths by suicide in females. Issues identified in the deep dive included: *A mental ill-health diagnosis and /or history of contact with mental health services), Adverse Childhood Experiences - most often related to sexual abuse, but also loss of or separation from parents, History of self-harm, History of alcohol or substance abuse, Parenting / carer stress, Financial stress, Domestic abuse Workplace stresses and adjustment challenges, particularly for those in a health, care or other frontline role (including childcare and police), Neurodiversity, Bereavement and grief, History of disordered eating, Denial of suicidal intent at the time of last contact with services.* As discussed above the trend appears to have returned to pre-2020 levels, but remain of obvious importance and concern.
Neurodiverse People	Neurodiversity refers to the different ways the brain works and interprets information. It is often used as an umbrella term for a spectrum of conditions such as autism, attention deficit hyperactivity disorder (ADHD), dyslexia, dyspraxia, tourette syndrome and complex tic disorders. Neurodiversity was identified as a risk factor for suicide in the 0-25 suicide audit (2020), with further qualitative analysis recommended of the impact of waiting for an autism assessment on children and young people's mental health and suicide risk. It is estimated that 1 in 7 people (approximately 15% of the UK population) are neurodiverse[11]. It is well documented throughout literature that neurodiverse conditions can increase the risk of suicide, for both adults and children and young people. NICE guidance recognises that people with autism are at higher risk of suicide[12] . Research also shows that late diagnosed adults appear to be at the highest risk of suicidal thoughts and behaviours, demonstrating the importance of identification and addressing needs at the earliest opportunity[13].Data on the number of children and young people with a statement of special educational needs (SEN) or education, health and care (EHC) plan for 2020/21 by primary need for

[11] Autism and.. Oxford Health (2021). Available Autism and.. - Oxford Health NHS Foundation Trust. Last accessed 26/08/21
[12] NICE (2018). NICE guidance on preventing suicide in community and custodial settings [NG105]. National Institute for Health and Care Excellence. Available: https://www.nice.org.uk/guidance/ng105. Last accessed 04/08/21
[13] Supporting autistic children and young people through crises: Autistica. Available: https://www.autistica.org.uk/downloads/files/Crisis-resource-2020.pdf Last accessed 17/08/21

	pupils enrolled in schools and nurseries in Berkshire[14] gives an indication of the number of children that are neurodiverse. A needs-led rather than diagnosis led approach has been adopted throughout Berkshire, which allows for pre-diagnostic support to be put in place for children and young people once needs become apparent. This support potentially reduces the risk of suicide for neurodiverse children and young people as interventions can be put in place as soon as needs are apparent and can reduce isolation experienced.
Routine and manual employed people	In Berkshire, between 2015 and 2019, a quarter of people dying from suicide had an occupation group of 'Skilled Trades Occupations' (26%).
Gambling	Gambling related harm is a risk factor for suicide and is a growing area of public health concern. In 2019/20, 11% of gamblers contacting the National Gambling Helpline said they had experienced suicidal thoughts, either currently or in the past [15]. Additional funding is being made available to support treatment services for problem gambling and to monitor the impact of COVID-19 on gambling behaviour. Gambling operators are putting in place additional measures to increase protections for those who might be at risk of gambling harm.
Economic Context and Deprivation	It is well recognised that the reasons why people die by suicide are complex, arising from a wide range of psychological, social, economic and cultural risk factors. People who are socioeconomically disadvantaged or who live in areas of socioeconomic deprivation have an increased risk of suicidal behaviour. Features of socioeconomic disadvantage include; low income, unmanageable debt, poor housing conditions, lack of educational qualifications, unemployment and living in a socioeconomically deprived area[16]. What is more, poor mental health makes it harder to deal with money problems and vice versa[17]. The NCISH 2021 report on suicide by middle-age men[18] found a number of findings associating suicide with economic precursors. Overall, 57% of men were experiencing economic problems including unemployment, financial problems, or problems finding stable accommodation. Almost a third of men included in the study were unemployed at the time of death, with almost half of these unemployed for over 12 months. Twice the proportion of men were living in the most deprived areas of England (27%) compared to those living in the lest deprived areas (14%). Alcohol and drug misuse were particularly common amongst men who were unemployed, as it was amongst those who were bereaved, or had a history of violence or self-harm. Some people are more economically or financially vulnerable than others, and this number is on the rise. Individuals who are young, low-

[14] Figures are for state-funded nursery, primary, secondary and special schools, non-maintained special schools and pupil referral units. They do not include independent schools

[15] Suicide awareness and prevention training. Gamcare (2020https://www.gamcare.org.uk/news-and-blog/news/gambling-charity-and-samaritans-launch-bespoke-suicide-awareness-and-prevention-training/

[16] Dying from inequality. Samaritans (2017). Available:https://media.samaritans.org/documents/Samaritans_Dying_from_inequality_report_-_summary.pdf. Last accessed 09/09/21

[17] Money and mental health, the facts. Money and mental health (2019). Available: https://www.moneyandmentalhealth.org/wp-content/uploads/2017/06/Money-and-mental-health-the-facts-1.pdf. Last accessed 09/09/21

[18] Suicide by middle aged men. NCISH (2021). Available NCISH | Suicide by middle-aged men - NCISH (manchester.ac.uk). Last accessed 02/09/21

	paid, Black, in self-employment and those with low education levels or live in large families have been disproportionately affected by the current COOVID-19 pandemic. These groups are more likely to have lost their jobs, not be working any hours or had their pay cut[19]. Across England, more than 1.5 million people are experiencing both problem debt and mental health problems. An estimated 46% of people in problem debt also have a mental health problem. Almost one in five (18%) people with a mental health problem are in problem debt. Financial problems are a common cause of stress and anxiety with people in this position not asking for help due to stigma around being in debt. Suicide can be seen as a way out of debt for some people who are struggling and more than 100,000 people in England attempt suicide while in problem debt each year (MMHPI) (2018)[20] Long-term factors such as persistent poverty and financial insecurity can put people at an risk of becoming suicidal, as can sudden triggers like the intimidating and threatening letters people receive from lenders. Providing debt management advice and support to people in debt will help to reduce an individual's risk of death by suicide, especially if they are experiencing poor mental health. There is a lot of support and help available for people, but awareness can be low. Neighbourhoods in Berkshire are not evenly distributed in terms of affluence with Reading and Slough having higher concentrations of people living in deprivation, alongside others with relative wealth.
LGBTQ people	Data on the LGBTQ+ community at a local level is very limited and there is a reliance on national survey data to understand the needs of this group. Facts and figures presented by Stonewall charity include the following findings which are particularly relevant to the topic of suicide in young LGBTQ people: • Half of LGBTQ people said that they've experience depression in the last year • 2/3 bisexual women and just over half of bisexual men having experienced anxiety • Nearly half of LGBTQ pupils are bullied for being LGBTQ in Britain's schools • More than 4/5 transexual young people have self-harmed • 3/5 lesbian, bisexual, and gay young people who are not transexual have self-harmed • More than 2/5 transexual young people have attempted to take their own life • 1/5 gay, lesbian and bisexual young people who are not transexual have attempted to take their own life.
The Bereaved	Those who are bereaved by suicide face a higher risk of mental ill-health, suicide attempts death by suicide.[1] [2] [3] The Support After Suicide Partnership summarises the particular challenges which mean that those bereaved by suicide are less likely to receive support from family and friends than others going through a bereavement.[4]

[19] COVID-19 recession is having a disproportionate impact on most vulnerable. LSA (2020) Available: https://www.lse.ac.uk/News/Latest-news-from-LSE/2020/h-August-20/COVID-19-recession-is-having-a-disproportionate-impact-on-the-most-vulnerable Last accessed: 09/09/21

[20] A silent killer. Money and mental health (2018) https://www.moneyandmentalhealth.org/wp-content/uploads/2018/12/A-Silent-Killer-Report.pdf Last accessed 09/09/21

Sudden deaths can lead to a complex bereavement, with those bereaved by suicide often experiencing particularly intense shock, as well as challenges linked to the stigma of suicide.[5] These stigmatising factors can mean the bereaved person is avoided or feels judged, and connections with social and support networks are weakened. People's awkwardness in discussing death is often magnified when the death is by suicide, and this can leave the person who is bereaved feeling especially isolated. Conversely, high interest in the suicide – from communities and from the media – can make it difficult for people to grieve in private.

Bereavement is highlighted in the Berkshire Suicide Audit, the Berkshire deep-dive into female suicides, and The National Confidential Inquiry into Suicide and Safety in Mental Health's reports into suicide amongst both children and young people and middle-age men.
Bereavement by suicide can be particularly devasting to the lives of those around the person who has died. People bereaved by suicide are at a greater risk of suicide themselves. Bereavement by suicide was highlight in 6% of subsequent suicides in the Berkshire Suicide Audit (2018).

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Survivors of Bereavement by Suicide (SoBS) is a national charity set up to offer support to adults bereaved by suicide. It is the only organisation offering peer-to-peer support to all those over the age of 18, impacted by suicide loss in the UK. It helps those bereaved by suicide to support each other, at the time of their loss and in the months and years that follow. SoBS offers peer led support groups, online virtual support groups, a national telephone helpline, online community forum and email support.

Amparo a specialist suicide post-vention support service, part of the Listening Ear group of counselling services has been commissioned to deliver services from 1st July 2022, covering Berkshire West, East, Oxfordshire and Buckinghamshire as the commissioned bereavement support provider for the patch. The initial contract is for two years to 2024.

There is recognition that staff may feel responsible for a suicide event, or not having done more to prevent it. Although these feelings are always misplaced, they can prolong the trauma if not managed effectively. Staff members may also experience anger, flashbacks and post-traumatic stress.

Appendix C Summary of the Cube Resource

The Cube:

Fig 1 A Cube - the inspiration for the resource[1]

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. It 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.

The Cube is a "living document" and will be updated over time to ensure that it keeps pace with the evolution of the agenda and new resources, links and service offers. Discussions are underway on where the resource can be hosted and shared with the Berkshire system.

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[2], etc.**

Users enter the resource via the face of the Cube that aligns to their 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 resource was to have been published in December 2022, but this has been delayed slightly to ensure linkages to the refreshed national strategy and updated Nice guidance.

It will be available and circulated in late January 2023.

[1] Image from Shutterstock.com item 1706314639
[2] LEDER - the NHS Learning Disability Mortality Review

Appendix D Outline of potential member and executive officer facing briefing materials

The Suicide Prevention agenda is a highly complex and essential aspect of local and regional mental health support. With a National Strategy delivered via regional and local SP works there is an increasing need to update local system leadership and professionals on developments that are occurring at National, Regional, and Local level.

There are a number of key components that could help update and inform local system leadership on the Suicide Prevention Agenda and it is proposed that the Pan Berkshire Partnership develops a rolling programme of role specific updates and briefing materials - in partnership with local area teams - to ensure regular updates on SP are available to local system leaders.

Given the scale of the agenda and the diversity of resources and capacity and experience available across the Berkshire system it is likely that some areas may already have all – or at least some - suggested inputs and materials already in place or under development. Suggestions for additional inputs are invited and sharing of these requested to help progress the works across the Berkshire system as a whole. Most briefings would be delivered online but could on request be in person with appropriate notice and scheduling.

Senior Local System Leadership	**Outline of Suggested Inputs Briefings And Materials**
Local Area Elected Members	• Input to local member induction packs – and briefings as required – specific more detailed version for portfolio leads • High level Overview of the SP agenda - Aligned to local Public Health in all policies works including National Strategy, Regional Strategy and Action planning • Local context, data and trends - overview • Local Action Planning (with Local place-based teams and leadership) • The Zero Suicide Agenda • How to talk about SP - Destigmatising and Addressing the issues across local communities • Resources to support your constituents – specific concise support and signposting materials, briefings (and if required training) on SP in the context of local Councillor ward-based Surgeries and face to face working
Local Area Executive Leadership Teams	• Input to local induction packs – and briefings as required • High level Overview of the SP agenda • National Strategy, Regional Strategy and Action planning • Local Action Planning (with Local place-based teams and leadership) • The Zero Suicide Agenda • How to talk about SP - Destigmatising and Addressing the issues across local communities • SP in all policies – aligned and coterminous works- supporting the strategy, the workforce and community • Local context, data and trends

Appendix E summary of the National Suicide Prevention Alliance (NPSA) membership advantages and potential local benefits

Context: The NSPA is a national collaborative group of organisations and individuals devoted to the prevention of suicide in the UK. With two options for membership, Individual membership - NSPA and Organisational membership - NSPA, the NSPA seeks to encourage collaboration and the sharing and promotion of best practice resources, initiatives and guidance aimed at preventing suicide. In the Berkshire West region the only published membership of the NSPA is within the West Berkshire Council area where the West Berkshire Volunteer Centre is a member as part of its overall support and co-ordination role for Suicide Prevention in that area. In Berkshire East only Slough Borough Council is signed up as an NSPA member, though an all-council motion in that authority has urged wider promotion of NSPA membership across the Berkshire East system.

Benefits of Direct Membership: There are several benefits that membership of the NSPA brings:

- Clear, visible commitment to the SP agenda – which is useful at individual and corporate levels and includes the right to include NSPA logos and references in local or regional publications, and can stimulate and energise focus on the SP agenda including a "SP in all policies approach"
- Access to NSPA bulletins, updates from the National and regional SP networks, emerging research, briefings and opportunities to collaborate or contribute to ongoing works and best practice resource development
- Publication of member organisation details and resources on the NPSA website enabling promotion of local works and priorities
- Attendance of NSPA events and voting rights for and election of steering group members

The Commitment: Members are required to abide to a Membership Agreement which sets out basic conduct for NSPA members, including communications guidelines on how the NSPA logo and materials can be used. Members are called to:

- Support and promote the aims of the NSPA as set out in the NSPA Declaration
- Nominate a representative to attend and vote at the members' meeting
- Update the NSPA on local priorities and challenges for publication via the NSPA website and report on progress at least once a year
- Share information, contacts, intelligence, and good practice within your own organisation, with the NSPA and collaborate where possible with other members
- Promote membership of the NSPA (adhering to branding/usage guidelines)
- Contribute resources to the NSPA's work if they can – either a financial donation or support in-kind
- Be respectful of the balance between promoting relevant products and services with other NSPA members and the inappropriate use of member communication channels.

Process: Membership is accessed through a simple online application form where details of the individual or organisation applying are sought, and materials are requested to inform the NSPA members listing and information

Suggested next steps: It is suggested that each local authority actively considers and takes up membership on an individual basis to fully benefit from the linkages and focus this can provide to their local systems. In time it would be ideal if all Berkshire system partners signed up to the NSPA.

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