Suicide Prevention Action Plan for Portsmouth 2018 -2021

Name:	Portsmouth Suicide Prevention Action Plan
Duration:	2018 – 2021
Relevant strategies:	Includes but not limited to: Health and Wellbeing Strategy; Anti-bullying Strategy; A Strategy for Improving Wellbeing and Resilience in Education; Safer Portsmouth Partnership Plan; Tackling Poverty Strategy; 20/20 Vision: Five Year Plan to improve mental health and wellbeing in Portsmouth
Board responsibility for monitoring plan:	Portsmouth Health and Wellbeing Board
Owner:	Portsmouth Suicide Prevention Partnership (PSPP)
Implementation date and review date:	Implementation: From March 2018. Quarterly monitoring and annual review

Plan on a page: The Portsmouth approach to suicide prevention:

To be inserted following sign-off of content (will summarise final content).

Aim

Death by suicide is preventable. Each life lost is a tragedy. One suicide will always be one too many.

We aim to reduce the number of suicides in the city by at least 10% over the next three years, and provide support for those bereaved or affected by suicide. This 10% reduction is in line with the 5 Year Forward View for Mental Health (Independent Mental Health Taskforce for NHS England, 2016).

By combining the national and local evidence base, we have identified seven key areas for action to support delivery of this aim:

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

Context

- Suicide is used in this Plan to mean a deliberate act that intentionally ends one's life.
- Suicide is often the end point of a complex history of risk factors and distressing events.
- Suicide is a major issue for society and a leading cause of years of life lost. Suicides are not inevitable. There are many ways in which services, communities, individuals and society as a whole can help to prevent suicides.
- Around 24 people, about 78% males, take their own lives by suicide each year in Portsmouth. This is higher as a rate than the England average.
- Suicide affects children, young people and adults – whether by taking their own life or as a person bereaved by suicide. Death by suicide (both nationally and locally) is highest in middle-aged men (peaking at 40-44 years). Nationally, suicide is a leading cause of death for young people aged 15–24 years.

Approach

Inclusive of self-harm: The relationship between suicide and self-harm is complex. We know that many people who die by suicide have a history of self-harm, and we know that self-harm is a significant concern in its own right. This strategy will consider self-harm in relation to suicide risk.

Partnership: As a large percentage of suicidal individuals are not in contact with health or social care services, action is also required beyond the health and social care system. Real partnership is required with community groups, local business and the third sector to help identify and support people at risk of suicide and those bereaved by suicide. Key messages learned from practice and research are that suicide is preventable, that it is everyone's business, and that collaborative working is key to successful suicide prevention. This Plan has been developed by a wide range of partners to ensure that is a collaborative effort, and that action to prevent suicide is a shared responsibility across Portsmouth. Having all partners committed to contributing time to supporting action, and identifying any supporting resource, is important given that there is no new financial resource to support this Plan.

Prevention and early intervention: The Plan supports taking early action to prevent individuals from reaching the point of personal crisis where they feel suicidal. This requires action much earlier and across a range of settings from general practice, to schools, the workplace and community groups.

Life-course: This Plan takes a "life course" approach as advocated by the Marmot Review (2010)[1], and aligned national mental health and suicide prevention strategy.

Evidence based: This Plan is informed by the evidence base. It uses national and local evidence to both identify areas of focus and specific need, and to inform the actions that will be taken to address need.

How we will measure success

Ultimately, we want to see a reduction in Portsmouth's suicide rate. However, due to the low numbers of suicides it is difficult to show a statistically significant improvement in suicide rates across a local area and additional (proxy) measures will be used to assess the Plan's success. This includes for example, levels of self-harm and stigma in the population. Achieving a reduction in suicides is challenging in times of austerity as we know that higher levels of people are living with financial stress, which is a risk factor for poor mental health and wellbeing and increases suicide risk.

[1] The *Marmot Review* stresses the importance of taking a *life-course* perspective and recognising that disadvantage accumulates throughout *life*. For further information see the Marmot Review report. 2010. Fair Society, Healthy Lives. Available at: http://www.instituteofhealthequity.org/resources-reports

National policy

In 2012 the government published *Preventing Suicide in England: A Cross Government Outcomes Strategy to Save Lives*[2]. The strategy identifies six key areas for action:

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.

Public Health England (PHE) has published a document designed to assist in the implementation of the national guidance, which refers to the same six key areas for action. It also includes recommendations from the All-Party Parliamentary Group (APPG), which suggests that the following three elements are vital to successful implementation of the national strategy[3]:
a. Undertaking a 'suicide audit' to understand local risk factors for suicide (PHE highlighted the need to make sense of local and national data).
b. Developing a suicide prevention action plan.
c. Establishing a multi-agency suicide prevention group to implement the plan throughout the local community.

In developing this Plan, all three of these have now been achieved.

In 2017 a (third) progress report of the cross-government suicide prevention strategy was published by the Department of Health and Social Care[4]. The report is used to update the 2012 strategy in five main areas:

- Expanding the strategy to include self-harm prevention in its own right.
- Every local area to produce a multi-agency suicide prevention plan.
- Improving suicide bereavement support in order to develop support services.
- Better targeting of suicide prevention and help seeking in high risk groups.
- Improve data at both the national and local levels.

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[2] Department of Health, HM Government. 2012. *Preventing Suicide in England: A Cross Government Outcomes Strategy to Save Lives.* Accessible at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/430720/Preventing-Suicide-.pdf
[3] Public Health England. 2016. *Local Suicide Prevention Planning. A Practice Resource*. Accessible at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/585411/PHE_local_suicide_prevention_planning_practice_resource.pdf
[4] Department of Health and Social Care. 2017. *Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives.* Accessible at: https://www.gov.uk/government/publications/suicide-prevention-third-annual-report

The advice of these national documents, as well as the experiences of other local authorities and international developments in suicide prevention have been taken into account in the development of our Portsmouth Plan.

Other key suicide and self-harm prevention national documents can be viewed at the following Public Health England link: https://www.gov.uk/government/collections/suicide-prevention-resources-and-guidance

Data and intelligence on suicide in Portsmouth

Key local data and intelligence sources that inform this section are as follows:

- Portsmouth Joint Strategic Needs Assessment (JSNA)
- Public Health England Suicide Profile
- Portsmouth Suicide Audits; 2013-14 audit, 2016 update (covering the period 2013 to 2015).
- Portsmouth Self-Harm Needs Assessment (2017)

Suicide rates

In 2016 there were 22 deaths due to suicide or undetermined intent[5] in Portsmouth, and between 2013 and 2016 97 deaths, which equates to roughly 24 deaths due to suicide or undetermined intent each year.

Over the last few years, the suicide rate in Portsmouth has been significantly higher than the national average. Over 2013-15 Portsmouth had an average of 14.1 deaths by suicide per 100,000 persons, which is significantly higher than the rate for England (10.1) and the South East (10.2). This is the highest local rate since 2001-03, and also higher than many of Portsmouth's comparator areas (using the CIPFA nearest neighbours definition[6]). Nationally, suicide rates have increased over the last ten years, coinciding with the economic downturn.

Gender and age

Between 2013 and 2016 78% of deaths due to suicide or undetermined intent were male and 22% were female. Men are therefore almost 4 times more likely to die from suicide or undetermined intent than women, which is roughly in line with the national trend (3.5 times more likely). For 2007-2016,

[5] Undetermined intent is defined as events where available information is insufficient to enable a medical or legal authority to make a distinction between accident, self-harm and assault.

[6] The Chartered Institute of Public Finance and Accounting (CIPFA) nearest neighbours attempts to relate Local Authorities by their traits by using descriptive features of the area each authority administers such as population, socioeconomic, household and mortality characteristics, rather than the services it provides.

female deaths have an older age profile compared with male deaths: 42% of all female deaths were aged 50+ years compared with 32% of male deaths. Female deaths peak at 45-49 years compared to the slightly younger 40-44 years for males. However, deaths by suicide account for a greater proportion of total deaths in younger compared to older age groups (younger people are less likely than older people to die of any cause), and particularly for males aged 18-19 years.

Contact with health services

28% of those who completed suicide were in current contact with specialist mental health services, most commonly the Mental Health Recovery Team and IAPT/Talking Change.

10% of those who completed suicide had seen a General Practitioner six days or less before their death, 33% within four weeks before their death, and 59% within 3 months. Of the cases who had seen a GP within the four weeks prior to their death, 64% of cases were in contact about their mental health; 33% about their physically health; and 3% were opportunistically seen.

Hotspots

Most deaths by suicide in Portsmouth take place at home (58%), but of those that take place in public spaces, the most common places were train stations and/or train lines and open spaces such as countryside (including woodland), the beach, or parks. More people lived in the most, compared to the least, socio-economically deprived areas of Portsmouth.

Groups at higher risk of suicide

The following groups are at higher risk of suicide in Portsmouth. These locally defined groups are in line with at risk groups identified by national guidance such as the national strategy report *Preventing Suicide in England: Two Years On.*

- Men, particularly middle-aged men and young men aged 18-19 years.
- People with a mental health diagnosis, especially depression – both those in the care of mental health services and those not in current treatment. For those in treatment high risk periods include the first 3 months (and especially first 2 weeks) post-discharge from acute mental health services (i.e. hospital).
- People experiencing:
  - Chronic pain, disability or other physical health status (the most commonly occurring “life event” identified by Portsmouth Suicide Audit)
  - Relationship difficulties (particularly for men)
  - Unemployment and/or financial difficulties
  - Housing difficulties and/or social isolation i.e. homelessness/living in a hostel/living alone

- Bereavement
- People with a history of self-harm or of attempting to die by suicide.
- People that have been a former prisoner/convicted of crime
- People with a history of alcohol and/or substance misuse (and including those with dual alcohol/substance misuse and mental health illness).
- People that have experienced physical and/or sexual violence and abuse (affects a higher proportion of women than men).

The national strategy also identifies looked after children, care leavers, young people in the justice system and veterans as being at higher risk of suicide. These groups may have been less visible in the audit findings of Coroner records where past occupations such as serving in the armed forces for example, may not have been recorded.

Groups identified in national guidance as needing a *tailored approach* to both improve their mental health and reduce their suicide risk, are as follows:

- Looked after children and/or care leavers.
- Military veterans.
- People who are lesbian, gay, bisexual (LGB) or gender reassigned.
- Black and Minority Ethnic (BME) groups and asylum seekers.

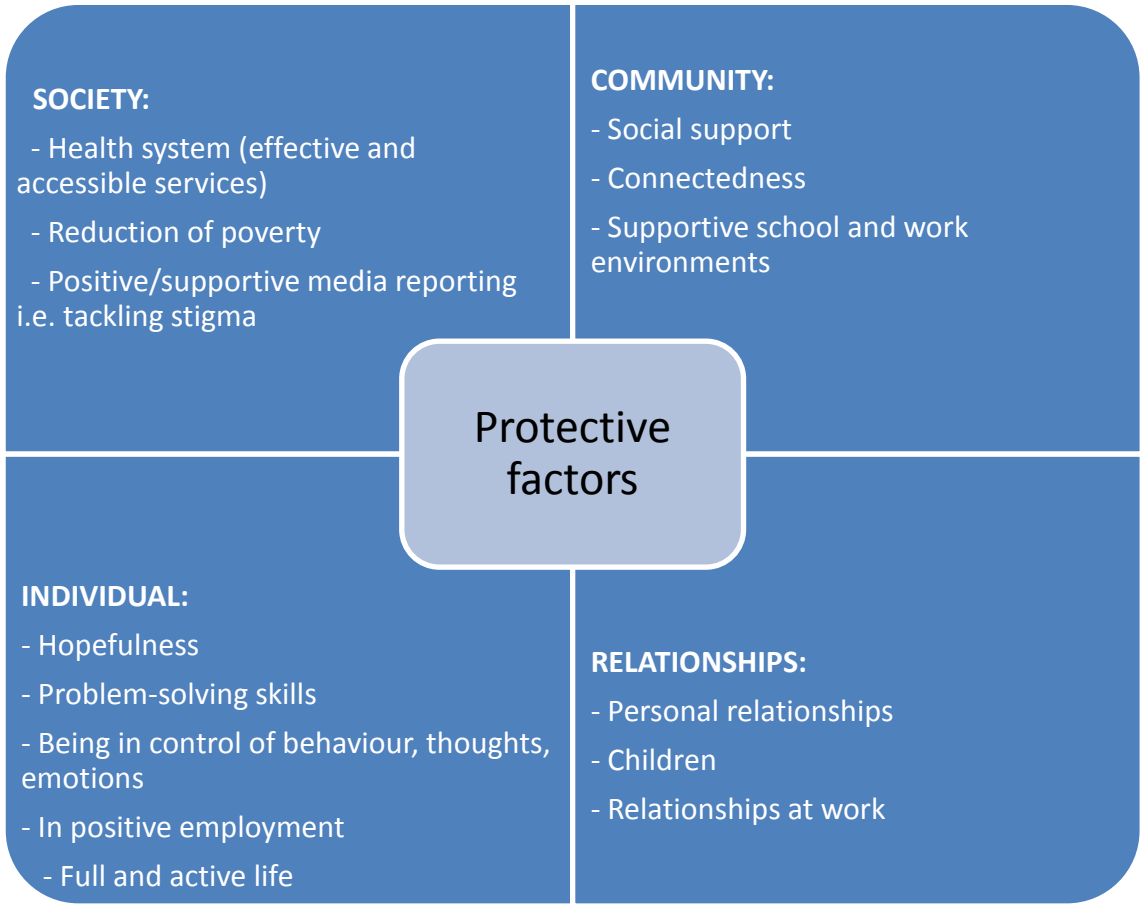
Portsmouth has higher rates of people who are separated or divorced, people living alone, people who are statutory homeless, looked after children, children leaving care, children in the youth justice system, alcohol related hospital admissions, and estimated prevalence of opiates or crack cocaine. Portsmouth has similar rates to England of recorded severe mental illness, self-reported happiness and anxiety scores, older people living alone, and unemployment[7].

Protective factors

When attempting to understand which factors promote resilience or vulnerability to suicide, it is important to consider a wide range of protective and risk factors. Suicide is complex, risk can change with circumstance, and what is a risk or protective factor for one person may not be the same for another in similar circumstances.

[7] Public Health England. *Suicide Prevention Profile.* Accessible at: http://fingertips.phe.org.uk/suicide#page/0/gid/1938132831/pat/6/par/E12000008/ati/102/are/E06000044

The diagram below highlights some of the known protective factors that help mediate against suicidal behaviour in those at risk:



Self-harm

Self-harm is a concern in its own right, as well as being a risk factor for completed suicide. Not everyone that self-harms will have suicidal thoughts, whilst not everyone that dies by suicide will have self-harmed. However, we know that previous self-harm is an important predictor for suicide. Between 2013 and 2015 57% of cases in Portsmouth had a record of self-harm or of attempting to die by suicide[8]. As there are links between the two, self-harm has been identified for inclusion in the Plan as a priority for further action.

National and local Portsmouth data suggest levels of self-harm are increasing, although only the 'tip of the iceberg' presents to healthcare services. Young people and adolescents (especially females) have disproportionately high rates of self-harm, both nationally and in Portsmouth. Self-harm in adults of all ages, taken together, also represents a significant health (and healthcare) burden. Public Health England (PHE) publish a metric which shows that local hospital admissions for 10-24-year-olds for self-harm are significantly higher than the national average, and have been for at least the last six years[9].

Risk factors for self-harm have been determined to be (but are not limited to):

- Women - rates are two to three times higher in women than men.
- Young people - 10-13% of 15-16-year-olds have self-harmed in their lifetime.
- Mental health disorders including depression and anxiety;
- People who have or are recovering from drug and alcohol problems.
- People who are lesbian, gay, bisexual or gender reassigned.
- Socially deprived people living in urban areas.
- Women of black and South-Asian ethnicity.
- Groups including veterans, prisoners, those with learning disabilities, and those in care settings;
- Individual elements including personality traits, family experiences (being single, divorced or living alone), exposure to trauma (including bullying, abuse or adverse childhood experiences), life events, cultural beliefs, social isolation and income.

Action planning for suicide prevention in Portsmouth

A multi-agency partnership group (Portsmouth Suicide Prevention Partnership) has been set up to agree strategy and actions to reduce the rate of suicide in Portsmouth. This partnership group includes representatives from the local authority, voluntary sector, community and acute health providers, emergency

[8] The local audit of Coroner's records will under-estimate the individuals that have self-harmed as it is well documented that many people who self-harm do not seek help from health or other services and so self-harm episodes are not recoded.
[9] See https://fingertips.phe.org.uk.

services, and other partners (see **Appendix 1** for details). The partnership has overseen the development of the Suicide Prevention Plan, which presents key areas and actions to take forward, with Leads from the partnership taking ownership for the delivery of different actions.

Delivery and governance

Portsmouth Suicide Prevention Partnership (PSPP) has responsibility for delivering on and monitoring progress towards the Suicide Prevention Plan. PSPP will report to the Health and Wellbeing Board, which has overall responsibility for suicide prevention. PSPP will meet quarterly and will report to the Health and Wellbeing Board on an annual basis.

Suicide Prevention Action Plan:

For each action a lead partner is named, though it is the expectation of the Portsmouth Suicide Prevention Partnership that all members will support the delivery of actions as relevant and required.

1. Objective: Achieve city wide leadership for suicide prevention

This Suicide Prevention Action Plan has been developed by a wide range of partners to ensure that is a collaborative effort and that action to prevent suicide is a shared responsibility across Portsmouth.

Ref	Target Group	Action	Timescale	Lead partner	Anticipated outcome
1.1	All groups	Establish a functioning multi-agency strategic group overseeing delivery of this Plan and related suicide and self-harm prevention activities (meeting quarterly).	June 2017	Public Health, PCC	Clear leadership and governance structure to coordinate suicide prevention efforts
1.2	All groups	Members of the Portsmouth Suicide Prevention Partnership (PSPP) to advocate suicide and self-harm prevention in their work areas and disseminate key massages, as well as "own" specific relevant actions.	Ongoing	All partners	Co-ordinated messages around suicide prevention across all sectors
1.3	All groups	Members of the PSPP share good practice, highlight current issues, identify funding and commissioning opportunities, and support collaborative work.	Ongoing	All partners	Co-ordinated delivery of actions within the Plan
1.4	All groups	The PSPP establishes strong links with national, South East and Hampshire-wide networks on suicide prevention.	Ongoing	Public Health, PCC ICS, PCC Providers	Opportunities to learn from other areas and to align suicide prevention work maximised
1.5	All groups	Create a Comms Plan that supports delivery of the Suicide Prevention Action Plan	June 2018	Public Health, PCC Media team, PCC	Co-ordinated communications supporting suicide prevention

2. Objective: Reduce the risk of suicide in key high-risk groups

The following groups are at higher risk of suicide in Portsmouth. These locally defined groups are in line with at risk groups identified by national guidance such as the national strategy report *Preventing Suicide in England: Two Years On.*

- Men, particularly middle-aged men and young men aged 18-19 years.
- People with a mental health diagnosis, especially depression – both those in the care of mental health services and those not in current treatment. For those in treatment high risk periods include the first 3 months (and especially first 2 weeks) post-discharge from acute mental health services (i.e. hospital).
- People experiencing:
  - Chronic pain, disability or other physical health status (the most commonly occurring "life event" identified by Portsmouth Suicide Audit)
  - Relationship difficulties (particularly for men)
  - Unemployment and/or financial difficulties
  - Housing difficulties and/or social isolation i.e. homelessness/living in a hostel/living alone
  - Bereavement
- People with a history of self-harm or of attempting to die by suicide.
- People that have been a former prisoner/convicted of crime
- People with a history of alcohol and/or substance misuse (and including those with dual alcohol/substance misuse and mental health illness).
- People that have experienced physical and/or sexual violence and abuse (affects a higher proportion of women than men).

Ref	Target Group	Action	Timescale	Lead partner	Anticipated outcome
2.1	All age groups	Embed suicide prevention in the Crisis Care Concordat programme.	Ongoing (from 2018)	CCG Solent NHS Trust	Improved risk identification, support and pathways to care.
2.2	All age groups Particular focus on middle-aged men, those living with depression and anxiety, and people living with chronic pain.	Map the different services, organisations and support groups (e.g. Advice Portsmouth, Citizens Advice, Foodbanks, Gyms, Libraries, Men's Sheds, Housing services as well as health services) that each of the at risk groups are likely to	2018	ICS, PCC Public Health, PCC	Identify opportunities for suicide prevention activities, risk identification, and to strengthen sign-posting, and referral to support.

		have frequent contact with – their "touch points" in order to identify gaps and where pathways can be improved. Mapping of current services that can be accessed by adults with low level mental health needs has been completed by the ICS and CCG.			Inform local mental health transformation work
2.3	All age groups	Use the above to identify suicide prevention opportunities, risk identification, sign-posting, and referral to support.	2018	Public Health, PCC	Improved intervention to reduce suicide Community groups/organisations identified and included in implementing the Suicide Prevention Action Plan
2.4	All age groups Target services and settings to train include the following: • Children's workforce including Schools and Colleges • Primary care (targeting those in high deprivation areas and with high levels of chronic pain); • Housing services; • Alcohol and substance misuse services; • Services and organisations in contact with people in socio-economic hardship e.g. DWP, debt and benefit advice agencies);	Provide and/or support the provision of mental health, self-harm and suicide prevention training to frontline staff and "touch points" (see above) to enable them to better identify those in need of help, provide support, and sign-post/refer.	2018-20	Public Health, PCC CCG	Improved competence and confidence in suicide prevention in front-line staff and key vocations/contacts in the community

	• Services/groups/business frequented by our target groups.				
2.5	Adults	Partners to fully engage with the Sustainability Transformation Plan (STP - NHS) workstreams that support mental health and wellbeing including adults with co-occurring conditions.	Ongoing	CCG Solent NHS Trust Public Health, PCC	Improved response to people with comorbid mental health and alcohol and/or substance misuse
2.6	All age groups	Establish a self-harm sub-group (reporting to the Portsmouth Suicide Prevention Partnership), which reviews the findings of the Self-harm Needs Assessment 2017, makes recommendations, and co-ordinates actions to deliver recommendations.	2018	Public Health, PCC Partners as appropriate	Delivery of specific actions to reduce self-harm in population from current baseline
2.7	Adults Target groups include middle aged men, those with depression and anxiety, and people living with chronic pain.	Contribute to the Portsmouth City Council workplace health programme to advocate good practice workplace mental health and wellbeing.	2018	HR, PCC Solent Mind	Mental health and wellbeing good practice embedded in workplace health programme (including mental wellbeing and resilience training)
2.8	All age groups Target groups include middle aged men who are socially isolated and/or economically inactive, adults with chronic pain, and young women (the later in relation to self-harm)	Deliver public awareness mental health campaigns (including suicide prevention and self-harm) that target at risk groups, reduce stigma, and encourage people to seek support.	Ongoing (from 2018)	Public Health, PCC Media Team, PCC	Reduce stigma surrounding suicide; increase help seeking behaviour with regards to mental and emotional health
2.9	Adults	Ensure acute trusts have robust suicide prevention plans in place, which include: • The undertaking of psychosocial assessments for all people who present at emergency departments for self-harm.	By end of 2020	Solent NHS Trust	Improved clinical intervention to reduce suicide rates

		• Robust discharge planning processes for vulnerable patients (heeding the House of Common's Health Committee's recommendation that people being discharged from inpatient care should receive follow up support within 3 days of discharge, rather than the current standard of seven days. • Compliance with of NICE guidelines			
2.10	Adults People experiencing financial difficulties.	Identify opportunities to provide early help to people with issues around money, debt or welfare benefits.	2018	PCC Tackling Poverty Coordinator DWP	Improved intervention, including early intervention, on debt, finance and welfare issues - where opportunities identified

3. Objective: Tailor approaches to support improvements in mental health in specific groups

As advised by the national guidance, the following groups may need tailored approaches to support improvements in their resilience and contribute to (with other actions) improved mental health:

- Looked after children and/or care leavers.
- Military veterans.
- People or are lesbian, gay, bisexual (LGB) or gender reassigned.
- Black and Minority Ethnic (BME) groups and asylum seekers.
- Those with complex (i.e. often multiple) needs.
- Plus some of the "at risk" groups identified through Priority 1.

Ref	Target Group	Action	Timescale	Lead partner	Anticipated outcome
3.1	Adults Vulnerable groups because of their mental health illness	Engage with the Adult Safeguarding Board to explore how the Board and PSPP can best work together on common issues to protect vulnerable	2019	Public Health, PCC Adult Safeguarding Board	Jointed up work on a shared agenda

	and/or because they are in the above groups.	adults from self-harming and/or completing suicide.			
3.2	Children and young people Vulnerable C&YP including looked after children and care leavers	For future suicide audits, complete a report for the Portsmouth Children's Safeguarding Board, which details any key intelligence and findings on deaths by suicide or undetermined intent by children and young people in Portsmouth. The report should include recommendations for how the PSCB and PSSG work together to protect vulnerable children and young people as appropriate.	By end of 2020	Public Health, PCC Portsmouth Safeguarding Children Board	Jointed up work on a shared agenda
3.3	Adults Those with complex needs i.e. MH, substance misuse, rough sleeping	Engage and support the Safer Portsmouth Partnership's work with the Complex Needs System Review group. Seek to support recommendations from the group.	2018 and ongoing	PH, PCC Solent NHS Trust CCG	Coordinated work on those with complex needs
3.4	All age groups Target groups: LGBT, BME, Veterans (ex), young offenders, bereavement support services.	Identify individuals/groups/organisations that can help engage with those identified as requiring tailored support (i.e. LGBT, BME groups, those with learning disabilities) and ensure they are aware of the pathways, services and resources in place so that they can best support individuals.	2018	Community Voluntary Sector (CVS) Independence and Wellbeing Team /PCC (IWT)	Improved awareness of pathways, services and resources by professionals and in turn residents Community groups/organisations identified and included in implementing the Suicide Prevention Action Plan
3.5	Adults and children and young people	Commissioned services recognise and put in place measures to support the specific needs of at risk and/or potentially vulnerable groups in need of additional support i.e. men only as well as mixed gender groups, LGBT groups.	By end of 2020	NHS Solent CCG ICS	Improved early intervention for specific vulnerable groups

3.6	All ages	Promote social prescribing as a means of improving mental health and wellbeing.	By end of 2020	Public Health, PCC CCG	Improved early intervention and access to protective factors

4. Objective: Reduce access to the means of suicide

Reducing or restricting access to the lethal means individuals use to attempt suicide is an important part of a comprehensive approach to suicide prevention.

Ref	Target Group	Action	Timescale	Lead partner	Anticipated outcome
4.1	Adults Those experiencing chronic pain	Promote safe prescribing of painkillers and antidepressants, including through the following: - Provide information to the CCG, GPs and hospital prescribers on deaths caused by prescription drugs, with recommendations. - Promote NICE guidelines on the appropriate use of drug treatments for depression. - Undertake a needs assessment for people addicted to prescribed medication. - Establish a time limited working group to oversee needs assessment and make recommendations.	October 2017 Remaining actions during 2018 and 2019	Public Health, PCC CCG	Safer prescribing and reduced fatal suicide attempts

4.2	All age groups	All agencies to work together via the PSPP to identify and manage hotspots for both completed and attempted suicides, including through the following: - Mapping the location of confirmed and possible suicides and self-harm locations to identify "hot spot" locations. - Informing partner agencies and those that have responsibility for buildings/land used for suicide to raise awareness and target training. - Establish a process for alerting train station staff if someone with high suicide risk goes missing from acute care. - Take action to reduce risk (i.e. install signage, barriers) in line with evidence base.	2018 and 2019	Public Health, PCC NHS Solent Network Rail British Transport Police Hampshire Police Other partners as needed	Improved intervention at suicide "hotspots".
4.3	All age groups	Work with the Local Authority Property and Housing team to include suicide risk in building design considerations for major refurbishments and upgrading of social housing stock and corporate assets	2019	Housing Asset Management, PCC	Suicide risk embedded in PCC housing stock (where major refurbishments and upgrading)
4.4	All age groups	Work with planning and developers to include suicide risk in new building design considerations, especially in relation to multi-storey car parks, bridges and high rise buildings that may offer suicide opportunities.	2019	Planning, PCC and other partners as required	Suicide risk embedded in building design of major new infrastructure

5. Objective: Provide better information and support to those bereaved or affected by suicide

The provision of timely information and support to those bereaved or affected by suicide such as families, friends, colleagues and peers, is important in supporting people through the different stages of bereavement and in preventing future mental ill health. We know that death of a family member or friend by suicide is a risk factor for suicide in the bereaved.

Ref	Target Group	Action	Timescale	Lead partner	Anticipated outcome
5.1	Families bereaved by suicide or a death of undetermined intent	Strengthen effective referral to bereavement support/services by emergency services that attend the death and those in contact with the families soon after bereavement from suicide occurs (i.e. Coroner's Office), so that referrals are appropriate and timely.	2018	Hampshire Police NHS South Central Ambulance Service (SCAS) Coroner's Office Bereavement services	Strengthened pathways and referral to bereavement support services. Standardise approach to supporting those bereaved by suicide
5.2	Families bereaved by suicide or a death of undetermined intent	Distribute and make available a Portsmouth Crisis Card to all appropriate agencies/services, which reference local support and the national "Help is at Hand" pack. Make available the national/local pack as appropriate.	2018	Public Health, PCC NHS Solent CCG British Transport Police Network Rail Voluntary sector partners	Information about bereavement support services more accessible
5.3	Families bereaved by suicide or a death of undetermined intent	Implement Suicide Real-Time data collection process by the Police (which will support the actions above); to early identify 'clustering' that would inform prevention and postvention planning.	2018	Hampshire Police Partners as appropriate	Implementation of real-time suicide surveillance
5.4	Families bereaved by suicide or a death of undetermined intent	Review the current bereavement support offer to families in Portsmouth, determine how best needs can be met, and work with services to strengthen the provision of suicide-specific bereavement support.	By 2020	Public Health, PCC ICS, PCC	Strengthened suicide specific bereavement support
5.5	Families bereaved by suicide or a death of undetermined intent	Build awareness raising on suicide-specific bereavement into core mental health and suicide prevention training for front line staff (including with first responders).	2018 and 2019	Public Health, PCC NHS Solent CCG All PSPP partners	More informed and competent work force

6. Objective: Support the media in delivering sensitive approaches to suicide and suicidal behaviours

There is a proven link between certain types of media reporting of suicide and increases in suicide rates. This objective aims to promote the responsible reporting and portrayal of suicide and suicidal behaviour in the media and reduce the risk of additional suicides

Ref	Target Group	Action	Timescale	Lead partner	Anticipated outcome
6.1	All age groups	Promote the responsible reporting and portrayal of suicide and suicidal behaviour in the media, including by encouraging use of guidance and advice on responsible reporting, and challenging the publication of harmful or inappropriate material with reference to the updated laws on promoting suicide.	Ongoing	PCC media team Voluntary sector partners	Reduce stigma around suicide
6.2	All age groups	Encourage local media to support the signposting of national helplines and local services for people that are affected by local campaigns and coverage of deaths by suicide or undetermined intent.	Ongoing	PCC media team	Increase in help seeking behaviour
6.3	All age groups	Build a proactive suicide prevention media campaign, which includes supporting World Suicide Prevention Day.	2018 and ongoing	PCC media team	Tackle stigma around talking about suicide

7. Objective: Support research, data collection and monitoring

It is important to build on the existing research evidence and other relevant sources of data on suicide and suicide prevention.

Ref	Target Group	Action	Timescale	Lead partner	Anticipated outcome
7.1	All age groups	In relation to the Suicide Audit:	By end of 2020	Public Health, PCC Coroner's Office	Audit to inform Suicide

		- Periodic audit of suicide and open verdicts undertaken to inform the JSNA and future refresh of the Suicide Prevention Action Plan. - The audit should continue to include findings of all serious incident reviews. - Explore with Coroner's office how occupational status can be better identified and recorded (to enable better targeting of prevention activities).			Prevention Plan refresh
7.2	All age groups	Circulate the key findings of the recent suicide audit to Partners, general practice and healthcare providers, to encourage learning from suicides locally.	2018	Public Health, PCC CCG/GP Alliance	Share learning from suicide audit with key partners to inform their practice
7.3	All age groups	Explore the need for information sharing protocols to support multi-agency suicide prevention, implementation options, and deliver agreed option/s as appropriate.	2019	Emergency services Solent NHS Trust CCG	Support joint working on suicide prevention
7.4	All age groups	Put in place processes to ensure that information on self-harm and attempted suicides informs suicide prevention activities.	2019	Public Health, PCC ICS, PCC NHS Solent Ambulance (SCAS) Hampshire Police CCG	Support joint working on suicide prevention
7.5	Adults	For a sample of attempted suicides, map the referral pathway for that person from point of contact with the first responder in order to A. check whether or not the correct referrals were made, B. whether they accessed appropriate services, C. if there are any gaps/needs in the pathway and referral process.	2019	Public Health, PCC with key partners	Learning on attempted suicides informs suicide prevention
7.6	Children and young people	Include a section in the YouSay Survey (with schools), which will provide supporting information on the status and views of children	2018	Public Health, PCC	Identification of need and

		and young people in relation to mental health, social and emotional wellbeing – to support identification of need and preventative activities.			preventative activities
7.7	All age groups	Establish links with local and leading universities on suicide and self-harm prevention to strengthen research links and academic input to the Partnership.	2019	Public Health, PCC	Strengthen academic and research links

Appendix 1: Portsmouth Suicide Prevention Partnership (PSPP) membership

Stakeholder team/organisation
British Transport Police
Children's and Adolescent Mental Health Service (CAMHS), Solent NHS Trust
Clinical Commissioning Group (Clinical Lead)
Commissioning Project Manager (Crisis Concordat representative), Integrated Commissioning Service, Portsmouth City Council
Coroner's Office
Department for Work and Pensions (DWP), Portsmouth Lead
Hampshire Police
Hampshire Probation
Media Team representative, Portsmouth City Council
Network Rail
Public Health Consultant, Portsmouth City Council (Chair)
Public Health Development Manager, Mental Health Lead (adults), Portsmouth City Council
Public Health Development Manager, Mental Health Lead (children and young people), Portsmouth City Council
Public Health Development Manager, Substance Misuse Lead, Portsmouth City Council
Public Health Intelligence, Portsmouth City Council
Red Lipstick (bereavement support for families bereaved by suicide)
Samaritans
Solent MIND
Solent NHS Trust
South Central Ambulance Service (Hants Operations manager)
Southern Health NHS Foundation (data & intelligence)
Tackling Poverty Co-ordinator, Portsmouth City Council
University of Portsmouth (Student Wellbeing Lead)