Sussex Partnership
NHS Foundation Trust

Towards Zero Suicide Strategy

December 2019 & Coronavirus Supplement - June 2020

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EXECUTIVE SUMMARY

Suicide is a major national public health concern - according to the World Health Organization (WHO), someone somewhere in the world dies by suicide every 40 seconds.

Inspired by the Zero Suicide Approach pioneered by the Henry Ford Hospital in the early 2000's, Sussex Partnership NHS Foundation is committed to suicide prevention and focussing our staff on continual quality improvement, and on 3rd May 2018 launched its own 'Towards Zero Suicide' strategy, outlining its commitment to work towards eliminating all suicides for people under our care.

PURPOSE

This document sets out a proposal to establish, define, and continue the work on suicide prevention in SPFT, as the Towards Zero Suicide Programme.

STRATEGY

Aligned to 'Suicide Prevention' from 'Implementing the Five Year Forward View for Mental Health'[1], and the NHS Long Term Plan, the strategy identifies a need for additional skills and/or capacity to deliver suicide action plans locally and across partner organisations.

Sussex Partnership NHS Foundation Trust shares the view that the suicide of those in our care should be seen as having been preventable at some point in that person's mental health journey. While the national target for the whole population is at least a 10% reduction in suicide, the programme team feels that a more ambitious approach of working towards zero should be the aim and is more in line with its ethos. By taking this approach, the Programme will help to deliver the 10% reduction.

Key aims for us include:

- Reducing the suicide rate within SPFT in line with national trends.
- Working in partnership with the STP to reduce the suicide rates across Sussex.

These aims will involve using information from within the trust to work with the STP to identify challenges, share learning and implement changes or initiatives that work towards shared objectives.

[1] FYFVMH; NHS England, 2016

Key priorities:

- Embedding the “10 Ways to Improve Safety” into all teams across SPFT (see below).
- Using QI as a methodology to bring about changes that reduce suicide risk.

The NCISH (National Confidential Inquiry into Suicide and Safety in Mental Health) “10 Ways to Improve Safety” are at the forefront of the programmes actions. This advice outlines ways in which mental health services can reduce the risk of harm or self-harm to service users. The outcomes of improved safety support the Towards Zero Suicide approach. We will embed this method.

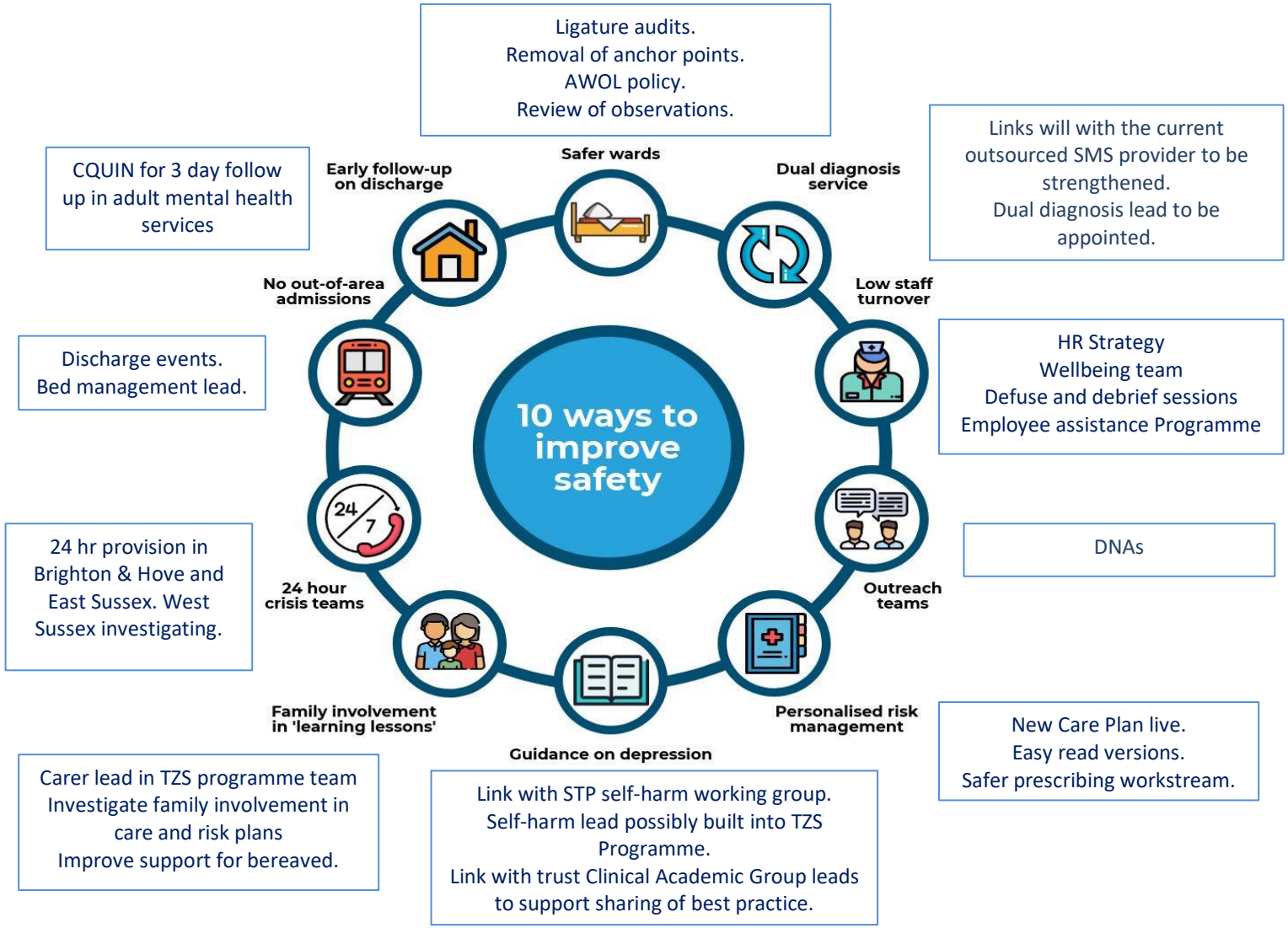
The aim of the Trust is to be an open and transparent organisation: able to share when things go right, but also when they go wrong. Learning from incidents is instrumental in bringing about change that may prevent suicides. So when things do go wrong, there is no individual blame; rather a systematic review of what could have been done better to prevent the incident is taken. Staff feel psychologically safe to report incidents, including near misses, and the organisation can then learn, improve, and share this learning.

10 WAYS TO IMPROVE SAFETY

In 2018 the National Confidential Inquiry into Suicide and Safety in Mental Health collected in-depth information on all suicides in the UK since 1996, with the overall aim of improving safety for all mental health patients. They launched a tool-kit which utilises a list of 10 key elements for safer care for patients, which provides crucial evidence to support service and training improvements. This will ultimately contribute to a reduction in patient suicide rates and an overall decrease in the national suicide rate.

The Programme intends to support and build on the current work relating to the 10 ways to improve safety in the trust. Wards will be able to drill down into the tool-kit, to identify current figures, and advise on reducing those figures in their own remits. The 10 ways to safety tool-kit is a key tool for the Towards Zero Suicide Programme and will using it in their work with different teams, wards and care delivery services. The Programme is aiming for the 10 ways to improve safety to be at the heart of the ambition to get to Zero suicides one day.

10 WAYS TO IMPROVE SAFETY STRATEGY 'ON A PAGE'



NCISH 10 ways to improve safety

STRATEGIC ALIGNMENT

National policies and frameworks underpin the base of this strategy and local evidence helped to tailor the approach. Themes from national and local research relating to suicides were reviewed and informed the strategy.

The Towards Zero Suicide approach is embedded into the SPFT clinical transformation strategy[i]. The programme brings together underpinning streams within the Clinical Strategy into one coherent programme of work which has been mapped on to the '10 ways to improve safety' domains, as well as being closely linked to the Trust's 2020 vision [ii]. It is fully recognised that this project forms part of a bigger picture – our blueprint for future services – and therefore it is vital that interdependencies are identified and optimised.

The Towards Zero Suicide programme is also aligned to the Sussex STP Suicide Prevention Working Group. This workstream contributes towards the development of joined up, accountable pathways of care, across agencies and services, that demonstrate good outcomes, value for money and compliance with national policy.

STAKEHOLDER INVOLVEMENT

The Towards Zero Suicide programme team includes the SPFT Patient and Carer. They ensure that the aims of the programme are supported, that both patient and carer voices are well represented and that they are at the forefront of the actions of the programme. They attend TZS Steering Groups and Programme boards to provide the patient/carer voice, as well as attend other meetings related to the programme to provide the patient/carer voice and share the TZS aims.

Close working relationships with local charities and organisations engaged with suicide prevention are key to the programme's work with the community and the Trust.

GOVERNANCE

The Towards Zero Suicide approach was signed off by the SPFT Trust Board in late 2017. The Towards Zero Suicide Programme has a Steering Group, chaired by the Chief Medical Officer which underwent a restructure in January 2019 to include a wider stakeholder group. Within the Towards Zero Suicide Steering Group, CDS Suicide Prevention Action Plans are tracked and supported routinely. The steering group reports into the programme board which consists of key corporate and operational stakeholders within the trust to sign off on key priorities.

The Towards Zero Suicide programme board reports into the Clinical Transformation Board. The clinical transformation board then reports into the wider STP mental health programme for the Sussex STP.

The programme also feeds into the trust Quality, Safety and Nursing boards. Quality and safety reviews which look at key lines of enquiry will be a tool for the programme to report and share best practice, whilst ensuring the trust is aligned to the 10 ways to improve safety.

TRAINING

A scoping review undertaken for HEE KSS at the start of 2018 identified significant skills, knowledge and confidence gaps around suicide prevention – particularly amongst GPs and primary care workers, clinical and non-clinical staff working in mental health trusts (including psychiatric liaison team and crisis team staff), emergency workers and A&E staff [iii]. It also identified a need for more information and signposting for families and carers.

In line with the findings of the scoping review, we have launched a face to face training package developed in collaboration with HEE KSS to provide support for GPs, mental health trust staff (clinical and non-clinical) and physical healthcare staff working with high risk groups. This package will be used within the trust to upskill clinical and non-clinical mental health workers. Primary care workers across the STP have made use of this and it remains available as a costed package.

The Towards Zero Suicide Programme Board signed off mandatory Suicide Prevention training in Jan 2019. This consists of two e-learning packages. The first element involves a non-clinical package and this is the Zero Suicide Alliance twenty minute video.

The second package involves a clinical package from Health Education England 'We Need to Talk about Suicide'. Questions will follow both packages to verify and validate that staff have completed the training package and can answer a values based test at the end.

We are proposing that apart from these two mandatory e-learning elements, we will have a non-mandatory suite of additional Suicide Prevention training:

- We will support face to face clinical risk training that involves an element of Suicide Prevention training. This is currently being delivered within the nursing directorate.
- We have introduced a Suicide Prevention package that was developed regionally with Health Education England across Kent, Surrey and Sussex. It will be a face to face Suicide Prevention package for mental health and primary care/ emergency care services and will be between half day and one day.

The aim is for all clinicians to have the level of skills required to clinically engage with patients and keep them safe. This level of skills will also be at the stated level in line with the national competency framework for suicide prevention. It is also the aim that non-clinicians are able to recognise those at risk, have the confidence to talk to the person and signpost them where to get help.

The TZS Programme will work to raise awareness so that people can recognise groups that maybe at risk, including those with problem gambling.

APPENDICES

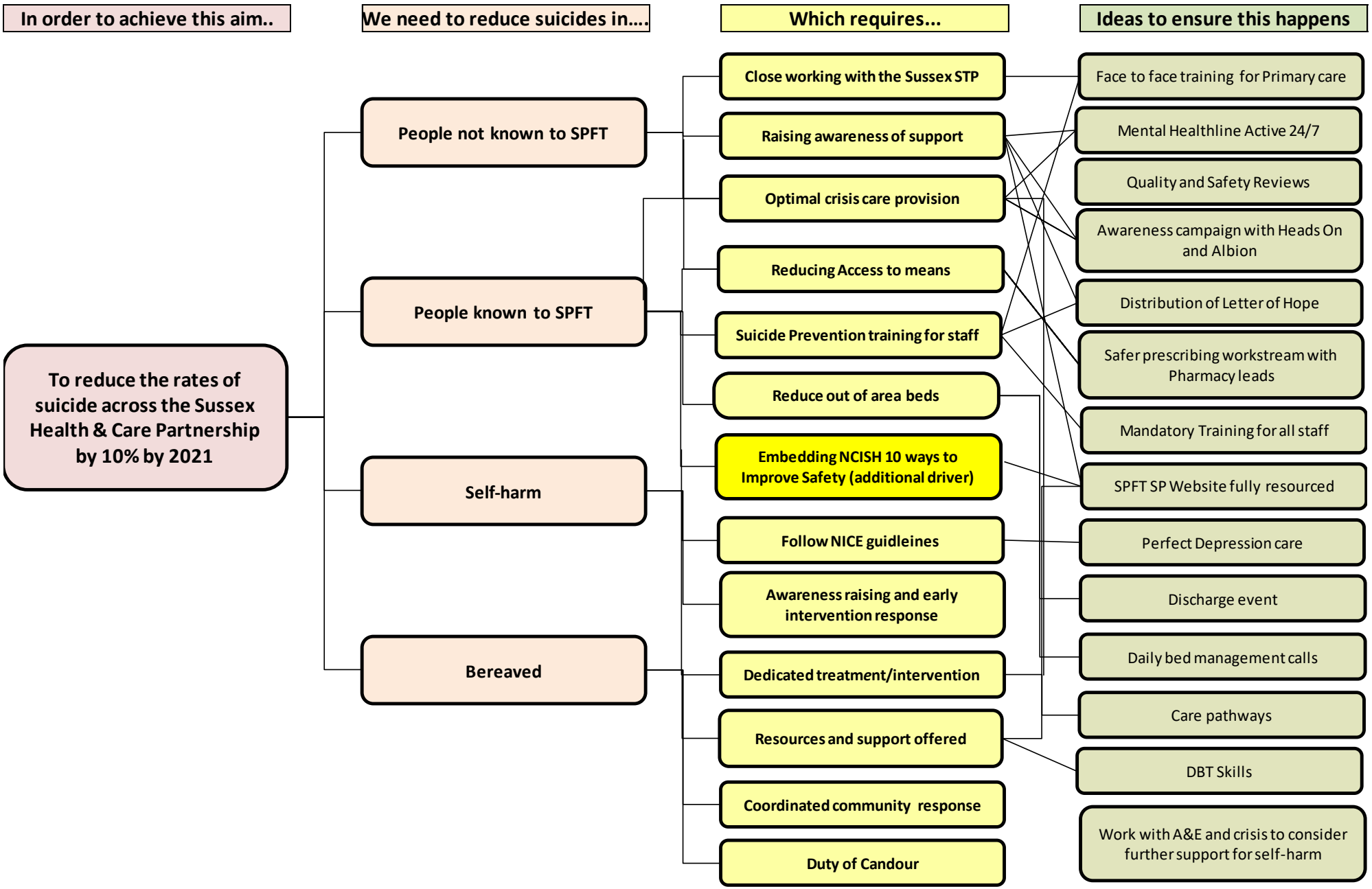
IMPLEMENTATION PLAN

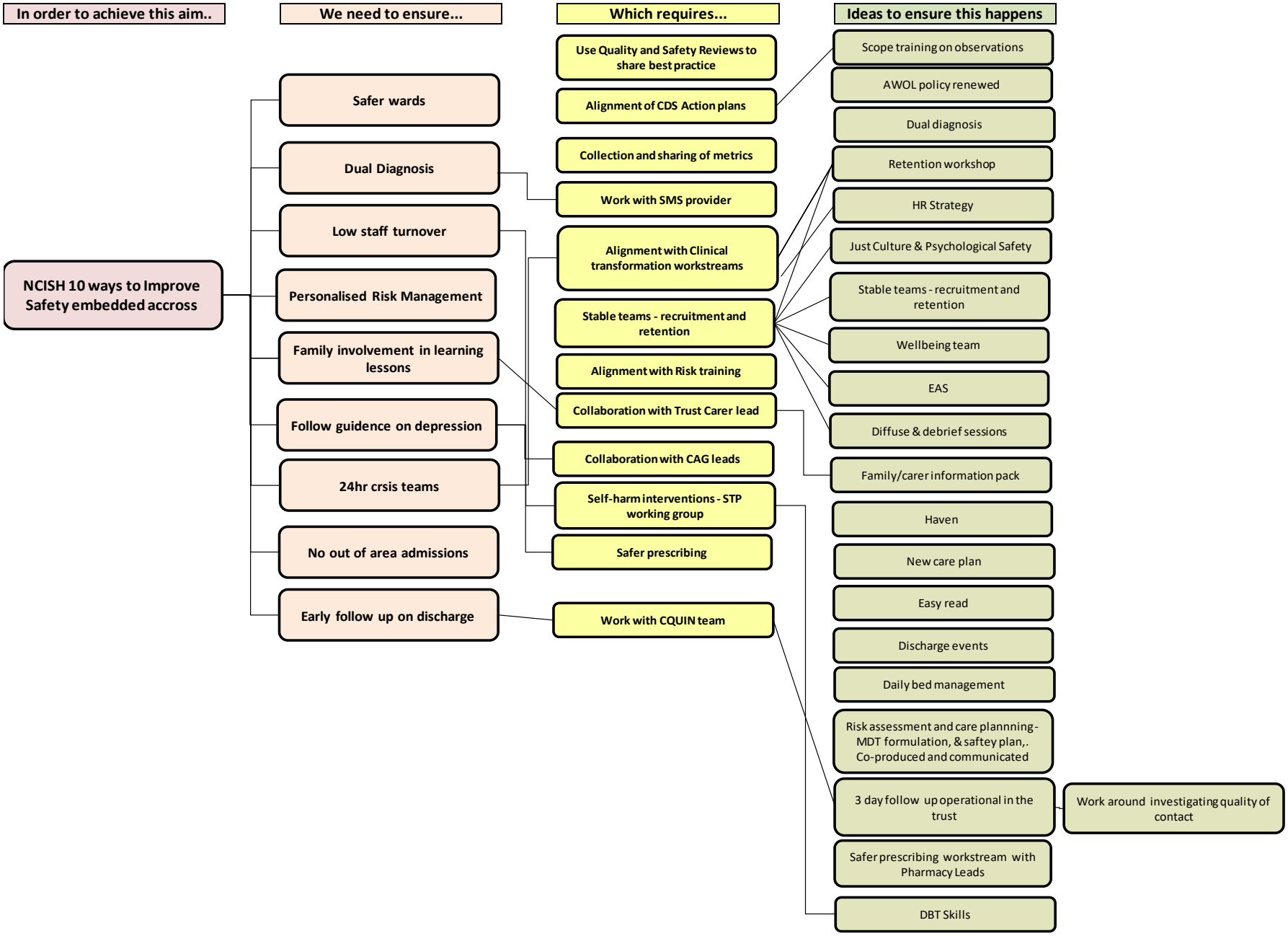
Goal	Actions	Current context	Next steps	Metric
Reduce trust suicides	Embed National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) '10 ways to Improve Safety' across the trust	The trust Towards Zero Suicide programme was launched in 2018. Raising awareness, providing training and embedding the NCISH 10 ways to Improve Safety are key actions of the programme. Quality and Safety Reviews.	Identify areas for improvement and provide support to Care Delivery Service to implement changes. Ensuring the 10 ways to improve safety is aligned to the Quality and safety reviews. Sharing good practice and learning from the reviews across the trust. Learning from SI reviews	Unexpected deaths obtained from safety committee and dashboard.
Train all staff in suicide prevention	Mandatory suicide prevention training for all staff (clinical and non-clinical) to improve confidence in suicide prevention.	Launched mandatory suicide prevention eLearning for all trust staff Aug 2019. Clinical package –'We need to talk about suicide' developed by Health Education England. Non-clinical package – Zero Suicide Alliance video.	All staff to refresh training every 2 years.	Trust learning platform (mylearning) % compliance. Quarterly update.
	Face to face training offer.	Training package developed in collaboration with Health Education Kent, Surrey, Sussex to provide support for GPs, mental health trust staff (clinical and non-clinical) and physical healthcare staff working with high risk groups. Launched March 2019 and 500 trained by Dec 2019 across trust and the STP.	Continue to offer training to trust staff. Investigate link with trust risk training.	Uptake from mylearning. Evaluation scores (Participants sent an evaluation form following training that asks for score on how it has improved; 1. Competence to formulate a risk assessment 2. Confidence in using the Triangle of Care as a model to engage with a family 3. Understanding of the impact of bereavement

				4. Competence in writing effective care, crisis and contingency plans)
Safer wards	Reduced ligatures	Ligature audits in place. Removal of anchor points.	The trust progress plan will help to identify necessary next steps. Link in with ligature group.	Ligature from anchor point (self -harm), Ligature without anchor point (self-harm), Ligature around neck (self-harm), Fatality ligatures, Serious Incidences - ligatures. All collected from the dashboard quarterly and shared with each Care Delivery Service.
	Reduced AWOL	The trust AWOL policy was reviewed at the Towards Zero Suicide (TZS) Steering Group meeting. East Sussex team doing an assessment AWOL activity	Quality Improvement project with Learning Disability Service involving police response plans. The trust progress plan will help to identify next steps.	AWOL incidences Serious Incidences - AWOL. Both collected from the dashboard quarterly and shared with each Care Delivery Service. AWOL report Safety Committee
	Observations	No formal training on observations currently in place. Competences discussed are on induction. Response to SI training.	To investigate the training provided on observations and any need for improvement	Number of staff trained in observations
Early follow up on Discharge	Trust Commissioning for Quality and Innovation (CQUIN) 3 day follow up	The trust made 3 day follow up a CQUIN which was completed in June 2019. 3 day follow up was signed off by the TZS Programme and is operational across the trust for adult mental health services.	LD to be added to the CQUIN. To review those not currently included. Investigations into the quality of the follow ups to be undertaken.	3 day follow up, 7 day follow up and breaches collected from the performance team and fed back to Care Delivery Services.
No out of area admissions	Multi Professional Discharge Event Daily bed management	The trust has held discharge events. Recent recruitment of bed management lead.	Scoping of daily bed management across the trust.	New patient admissions Out of Area Placement days collected quarterly per Care Delivery Service by trust performance team
24 hr crisis teams	Crisis teams.	The trust currently provides; Haven Ward (Millview) – 24 hour Woodlands 9am-9pm	Mental health helpline active 24/7 West Sussex considering 24 hour provision.	Opening hours of crisis teams.

		Café East Sussex CRHT - 24 hour		
Follow guidance on depression and self-harm	Scoping re self-harm work within the trust.	Scoping re self-harm work within the trust.	Link with STP self-harm working group. Self-harm lead possibly built into TZS Programme. Link with trust Clinical Academic Group leads to support sharing of best practice. Dialectical Behaviour Therapy (DBT) opportunity for clinicians.	Self-harm and SI self-harm collected from the dashboard quarterly and shared with each CDS Self-harm report from the Safety Committee. Evaluations. Number of clinicians developed. Possible uptake from STP.
Personalised risk assessments	New Care Plan live. Easy read versions. Haven	A new care plan was launched.		Percentage of patients with valid risk assessment collected quarterly per Care Delivery Service by performance team Clinical risk training compliance from mylearning
Low staff turnover	HR Strategy Wellbeing team	The trust has an HR strategy. Retention workshops take place, along with defuse and debrief sessions. There is also a staff wellbeing team. There is an Employee Assistance Programme in place.	Investigate defuse and debrief. Investigate bereavement support for staff.	Staff turnover (%) collected quarterly per Care Delivery Service by performance team Defuse and debrief data
Dual diagnosis services	CGL		Dual diagnosis lead to be appointed.	Serious Incidences - alcohol/substance use and Self-harm - alcohol/substance use collected from the dashboard quarterly and shared with each Care Delivery Service.
Family Involvement	Work with Trust carer lead	The triangle of care has been a key element of suicide prevention workshops	Investigate tools such as carenotes for ensuring family involvement in care plans and risk assessments Improve support for bereaved.	Tbc - % care plans produced with family involvement Tbc - % risk assessments produced with family involvement

Outreach Teams		Safer prescribing		Did Not Attend (DNAs) obtained quarterly from the performance team, per Care Delivery Service.
Resources	SAFE (suicide awareness for everyone)cards for East and West Sussex Letter of Hope	The trust produced a SAFE card providing help phone lines, websites and Apps for those at risk. The Letter of Hope was written by EBEs and has been put in letter and banner pen format.	Investigate merging East and West into one card for both. Include Mental Health Helpline. Have a distribution plan for the SAFE cards to target specific high risk groups/locations Have a distribution plan for the Letter of Hope. Consider adapting the Letter of Hope for young people.	KPI on Stay Alive App (There is a Stay Alive QR code on the reverse)
Raise awareness and support STP work	Workshops Steering Group events STP working Group	The trust has held workshops for various groups within the trust, steering group meetings for wider stakeholders and are part of the STP Suicide prevention working group.	Hold wider stakeholder events to raise awareness. Continue to work with the STP to include training provision for example.	TBC - Website traffic


In order to achieve this aim..
We need to reduce suicides in....
Which requires...
Ideas to ensure this happens
To reduce the rates of suicide across the Sussex Health & Care Partnership by 10% by 2021
People not known to SPFT
People known to SPFT
Self-harm
Bereaved
Close working with the Sussex STP
Raising awareness of support
Optimal crisis care provision
Reducing Access to means
Suicide Prevention training for staff
Reduce out of area beds
Embedding NCISH 10 ways to Improve Safety (additional driver)
Follow NICE guidleines
Awareness raising and early intervention response
Dedicated treatment/intervention
Resources and support offered
Coordinated community response
Duty of Candour
Face to face training for Primary care
Mental Healthline Active 24/7
Quality and Safety Reviews
Awareness campaign with Heads On and Albion
Distribution of Letter of Hope
Safer prescribing workstream with Pharmacy leads
Mandatory Training for all staff
SPFT SP Website fully resourced
Perfect Depression care
Discharge event
Daily bed management calls
Care pathways
DBT Skills
Work with A&E and crisis to consider further support for self-harm


In order to achieve this aim..
We need to ensure...
Which requires...
Ideas to ensure this happens
NCISH 10 ways to Improve Safety embedded accross
Safer wards
Dual Diagnosis
Low staff turnover
Personalised Risk Management
Family involvement in learning lessons
Follow guidence on depression
24hr crsis teams
No out of area admissions
Early follow up on discharge
Use Quality and Safety Reviews to share best practice
Alignment of CDS Action plans
Collection and sharing of metrics
Work with SMS provider
Alignment with Clinical transformation workstreams
Stable teams - recruitment and retention
Alignment with Risk training
Collaboration with Trust Carer lead
Collaboration with CAG leads
Self-harm interventions - STP working group
Safer prescribing
Work with CQUIN team
Scope training on observations
AWOL policy renewed
Dual diagnosis
Retention workshop
HR Strategy
Just Culture & Psychological Safety
Stable teams - recruitment and retention
Wellbeing team
EAS
Diffuse & debrief sessions
Family/carer information pack
Haven
New care plan
Easy read
Discharge events
Daily bed management
Risk assessment and care plannning - MDT formulation, & saftey plan,. Co-produced and communicated
3 day follow up operational in the trust
Work around investigating quality of contact
Safer prescribing workstream with Pharmacy Leads
DBT Skills

STRATEGY BACKGROUND

In 2017 there were 5,821 suicides in the UK[2]. Men account for three quarters of all deaths by suicide[3]. Suicide is the leading cause of death among young people aged 20 to 34 and among men under 50 in the UK, with those at the highest risk being men aged between 40 and 44 years old (a rate of 23.7 deaths per 100,000 population)[4]. Suicides have far-reaching impacts and can be devastating for families, friends, and communities, who are themselves then at greater risk of suicide[5]. Suicide is also devastating for those in caring roles and therefore support for staff working in potentially stressful environments is crucial.

It is estimated that around one third of those who died by suicide in England were in contact with mental health services in the 12 months leading up to their death. A further third were in contact with primary care services (most notably GPs) but not receiving specialist mental health support and the final third had no contact with health services at all in the year prior to death[6]. 63 per cent of those who die by suicide have a mental health diagnosis[7], and just over half have sought help following a previous attempted suicide – 26 per cent from their GP and 25 per cent from secondary mental health services[8]. Self-harm (including attempted suicide) is the single biggest indicator of suicide risk, with approximately 50 per cent of people who die by suicide having a history of self-harm[9] .

Suicide is a potentially avoidable death: preventable by public health interventions or high quality evidence-based care. Preventing suicide is complex and challenging. However, there are a number of effective solutions that can address or mitigate the variety of factors that collectively contribute to suicide.

The Five Year Forward View for Mental Health (FYFVMH) set a national ambition to reduce the suicide rate in England by 10% by 2020/21. To support this, priority areas for action were identified in the Government's National Strategy for Suicide Prevention[10]:

1. Reducing the risk of suicide in high risk groups
2. Tailoring approaches to improve mental health in specific groups
3. Reducing access to means of suicide
4. Providing better information and support to those bereaved or affected by suicide
5. Supporting the media in delivering sensitive approaches to suicide and suicidal behaviour
6. Supporting research, data collection and monitoring
7. Reducing rates of self-harm as a key indicator of suicide risk

[2] Office for National Statistics, 2017
[3] Office for National Statistics, 2017
[4] Office for National Statistics, 2017: 2016 UK Registration
[5] Department of Health, 2017
[6] Health Select Committee, 2017
[7] National Confidential Enquiry into Suicide and Homicide, 2017
[8] Department of Health, 2017
[9] Department of Health, 2017
[10] Department of Health, 2017

These priorities were subsequently strengthened in the Third Progress Report on the National Strategy[11], which expands the scope of the Strategy to include self-harm, and focuses particularly on prevention of suicide in middle-aged men, and increasing support for people bereaved by suicide.

Underpinning the delivery of the National Strategy was the Government's recommendation that every local area should have in place a multi-agency suicide prevention plan by 2017[12], which should set out targeted actions aligned to the national Suicide Prevention Strategy and evidence-based preventative interventions targeting high-risk locations and supporting high-risk groups in their local areas. As of February 2018, all nine local authorities in the region either already had a suicide prevention action plan in place or were in the process of developing one[13], and some of these plans are now being developed further. These action plans form the basis of a coordinated and strategic effort across communities, involving healthcare providers, local authorities, public health bodies and the third sector.

LOCAL TRENDS IN SUICIDE

Understanding the nature, incidence and prevalence of suicide within the region will be crucial in informing the approach and ensuring the plans are aligned to each area's suicide prevention action plans. As each local Care Delivery Service develops its own delivery plans, they will draw on detailed local information, working with local public health teams who have developed their own analysis of local suicide rates.

The public health teams will lead the development of the overall suicide prevention action plan for each local authority area and Care Delivery Service action plans will form part of the overall action plan.

Three summaries of SPFT data reviews that informed the strategy are detailed below, and cover:

- SPFT serious incident annual review- 2018 (Dorey, 2018)
- Clinical audit of unexpected deaths
- Local intelligence from clinicians

[11] Department of Health, 2017
[12] NHS England, 2016
[13] Public Health England, 2018

SPFT Serious Incident Review 2018

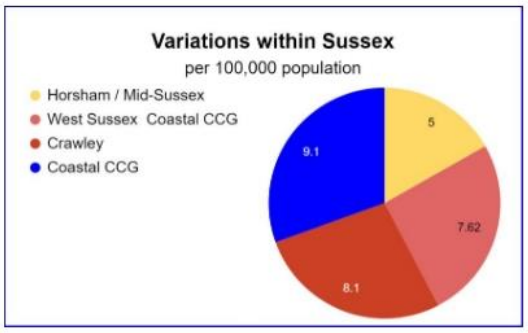
Rate in Sussex Partnership (Sussex & East Surrey) is 11.1 per 100,000 population

38th of 44 UK regions for number of suicides (low to high)

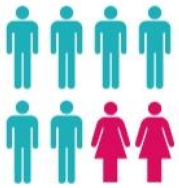
All areas have increased since 2014

Average rate of suicide for Brighton & Hove (15.2 per 100,000 population) is highest in the region, and significantly higher than national average

Brighton and Hove ranks 4th of the 152 local authorities (high to low)



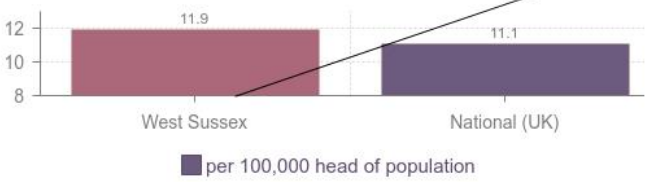
West Sussex figures mirror national statistics, with higher numbers of deaths occurring in the 45-54 age group.



In Brighton and Hove men were **3** times more likely to take their lives than women.

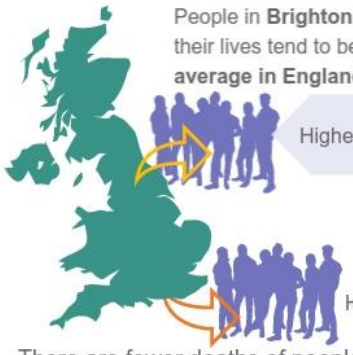
Average annual rate in Sussex higher than national rate

includes deaths of residents and non-residents



1/3 of East Sussex deaths are people who do not live in the county

80% of those visitors die at Beachy Head



People in **Brighton and Hove** who take their lives tend to be **younger than the average in England**.

Highest group aged **45 +**

Highest group aged **35 - 44**

There are fewer deaths of people over the age of 65.

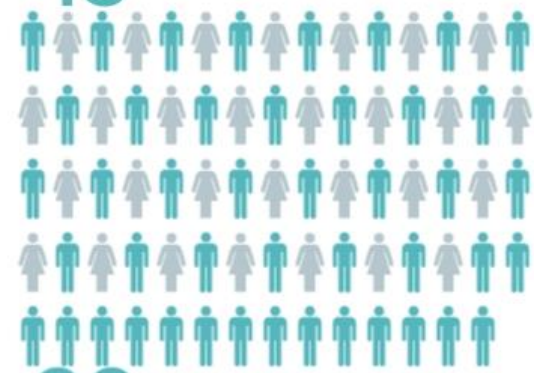
People living in **deprivation** demonstrated a **higher prevalence of suicide**, which is in keeping with other areas of Sussex.

Clinical Audit of Unexpected Deaths

The SPFT Clinical Governance Team completed an analysis of unexpected deaths which occurred during the reporting period 1 April 2017 to 31 March 2018. To date, 74 out of the 89 Serious Incident Investigations have been reviewed in detail with the findings as follows:

GENDER

45 patients involved in fatalities were male



29 patients involved in fatalities were female

The age range with the highest number of fatalities was 25-34 (17), followed by 35-44 (15)

25-34 35-44

People who are known in the **first year** of service are the most common group in terms of fatalities (32) and the SI data from 2015-17 also indicates this is a potentially emerging theme.

The most common methods of death; by hanging/ strangulation, overdose, then jumping/multiple injury, are the most commonly reported within the 2017 NCISH findings.

Conclusion- Key Recommendations for the Next Year

- Services to continue upward trend in reporting all incidents.

- Continue to seek a range of ways to share learning from incidents and serious incidents across the organisation.

- To work with teams to develop service improvement projects to enable the learning from incidents and serious incidents to lead to improvements in care in keeping with the Trust's work on establishing a Just and Learning Culture and using Quality Improvement methodology.

- To bring together incidents, serious incidents, complaints and Safeguarding investigations to enable a connected view of all learning.

Local Intelligence from Clinicians

Research carried out on completed suicides recorded by SPFT between March 2017-Aug 2018 has informed the Towards Zero Suicide programme. This research involved investigating each of the 202 suicides within that time period, to establish any common themes with admissions, diagnosis, demographics and Psycho-social factors involved.

Largest demographic groups:

Males (67%)

Single People (64%)

People Living Alone (51%)

When considering psycho-social factors, the most common factor for both genders was **loneliness**. It is worth noting that this was infrequently mentioned in admission notes. This was followed by relationship breakdown, then physical health and medication non-adherence.

Males

were more often diagnosed with psychosis, alcohol / substance abuse, and adjustment disorders

Females

were more often diagnosed with depression and personality disorders.

Alcohol and drugs play a big part in both admissions and suicides in the region. Increasing alcohol and substance misuse was a **determining** factor rather than a contributing factor in the suicide. For admissions there still seemed to be some level of control over the alcohol and substance intake. It is therefore **critical** that the Trust works to improve management of **dual diagnosis**, as per the **'10 Ways to Improve Safety'**.

In summary, for the Towards Zero Suicide programme to effectively reduce the number of suicides, alcohol and substance misuse and psychosocial factors must be properly addressed.

SPFT Towards Zero Suicide Programme Strategy Paper Supplement - Coronavirus June 2020

This is a supplement to the Towards Zero Suicide Strategy paper, put together in response to the Coronavirus pandemic.

The pandemic has impacted on some of the projects within the implementation plan of the strategy paper. Some have been on put hold, whilst others have been delayed or altered. All projects will be restarted as soon as it is possible and safe to do so. The NCISH 10 ways to improve safety are still key areas of focus for the programme and the link that initiatives have to them are highlighted below.

Whilst the 10 ways to improve safety remain key to the programme, we are also aware that in the current climate there is an increased need to work in partnership with external stakeholders to support the prevention of crisis and therefore the need for admission.

Risk factors for suicide include isolation, financial difficulties, accommodation problems, domestic violence, bereavement, anxiety which are likely to be challenges for a large number of people in the county during the pandemic. Therefore the programme has looked at new initiatives that can support people in response to the pandemic.

The programme has been involved in launching a young people's platform to support young people suffering with their mental health during Covid-19 and beyond. This initiative has been launched to ensure that young people, particularly whilst in lockdown have access to the support and the information they need to look after their mental health. This platform will continue following the coronavirus to ensure support for young people is provided 24hours ***(10 ways to improve safety - 24hour crisis teams).*** There could also be a potential for the development of other virtual initiatives for the adult community as following this initiative.

Being involved in a task and finish group to improve the support for victims of domestic abuse during Covid-19 has been a commitment of the programme. The rise in calls to domestic abuse agencies during the pandemic is a concern, as domestic violence victims are at increased risk of suicide. Possible outcomes from this group discussion are; suicide prevention training for the 3rd sector and domestic abuse training for SPFT staff.

The programme has been helping to provide Mental Health boxes for those in isolation. Community patients have been provided with these boxes as a result of organising funding, production and the distribution of boxes with OTs and service managers. This has involved linking up with OTs, Heads On and Sussex Police to provide boxes for domestic abuse victims, community patients, veterans and CAMHS plus others that are vulnerable, shielded or isolated.

Providing webinar suicide prevention training to Primary Care in partnership with the SHCP is planned. Upskilling GPs in a time when people face significant challenges to their mental health will lead to increased confidence in picking up warning signs, understanding risk and signposting patients.

The programme has been working closely with the Governance team to impact safer wards. An example of this being reviewing the findings of the rapid tranquilisation audit to feedback and bring about changes. ***(10 ways to Improve safety - Safer wards*)**

An A&E liaison pilot with the SHCP will aim to provide an A&E follow-up service to follow up with people post self-harm incidents, following the principle that they are likely to remain vulnerable during this period of time and to ensure that the agreed plan on leaving A&E has been followed through. For those without a plan, it will provide another opportunity to engage and support them. ***(10 ways to Improve safety - Following guidance on depression and self-harm)*** The ambition is for a pan-Sussex service. Commencing the pilot phase in Eastbourne, Brighton and Worthing will test the approach across the three areas. Key aims of the pilot are to; reduce A&E re-admissions, reduce and prevent further acts of self-harm and reduce the risk of completed suicide in patients who self-harm.

In collaboration with Brighton & Hove Albion (Albion in the Community), Heads On and Public Health, the programme will be working on reaching out to men through the Movember and Mental health campaigns. The Movember is a campaign that commits to making it ‘the norm’ for young men to be talking about their health (targeting colleges). The additional mental health campaign aims to reduce the suicide risk of middle aged men aged 30-50, a key risk group.

The appointment of a new dual diagnosis lead has provided the Programme with an opportunity to work in partnership to improve care for those that have mental health problems and problematic substance misuse. ***(10 ways to Improve safety - Dual diagnosis*)**

REFERENCES

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