Appendix 2

London Borough of Barnet Suicide Prevention Report 2017/2018

Authored by:

Natalie Daley (Health Improvement Officer)

Jeffrey Lake (Public Health Consultant)

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Introduction

The 2017/2018 suicide prevention report and action plan provides an update on progress made in 2016/2017 on the agreed actions to support suicide prevention in Barnet, and presents the actions agreed by partners for 2017/2018.

Following a recommendation from the Barnet Enfield and Haringey Mental Health Trust Tri-borough workshop in 2016 an audit of the coroner's data has been conducted. The results of this are also presented.

National Data

Statistics for death by suicide

The most recent ONS data are from 2015 and reflect the deaths that were registered in that year rather than the deaths that actually took place in 2015. The data show a slight increase in the rate of suicides in the UK in those aged 10 and over from 10.8 deaths per 100,000 (95% CI 10.5-11.1) population in 2014 to 10.9 per 100,000 (95% CI 10.6-11.1) in 2015[1], although this was not statistically significant. The change was driven by a rise in the female suicide rate, from 5.2 per 100,000 to 5.4 deaths per 100,000, while the rate in males fell from 16.8 deaths per 100,000 to 16.6 deaths per 100,000. The female rate was at its highest since 2005, however men are still three times more likely to die by suicide than females[1].

Among males the highest rates of suicide are in the 45-59 and 30-44 year age groups at 22.3 and 21.0 deaths per 100,000 population respectively. Both have been falling since 2013[1]. In comparison, under-30s had the lowest rate at 10.6, but this has shown a steady increase over the last few years[1].

As in males, the suicide rates in females were highest among those aged 45-59 and 30-44 at 7.6 and 6.0 per 100,000 population respectively[1]. However the 30-44 year old age group is the only one to show a decrease since last year. The lowest rates were in 10-29 year olds.

In female older people (60-74 year olds and 75 and over), the rate of suicides has increased since 2014; this is slightly more in 60-74 year olds (5.4 per 100,000) compared with those aged 75 and over (4.8 per 100,000 people)[1].

In 2015 hanging remained the most common method of suicide in both men and women. There was an increase in the proportion of deaths by hanging to 58% in men (55% in 2014) and 43% in women (42% in 2014)[1,2]. The second most common method of suicide was poisoning although this has fallen in both males (19% to 18%) and females (37% to 35%)[2].

[1]Suicide in the United Kingdom: 2015 registrations (2015) Office for National Statistics https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2015registrations [1][accessed online 25/1/17]

[2] Suicide in the United Kingdom: 2014 registrations (2014) Office for National Statistics http://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2014registrations [accessed online 25/1/17]

The proportion of people dying by other methods of suicide, including drowning and falling, has remained fairly constant over the last 10 years.

Local statistics

Data have been collected from the following sources to provide a comprehensive picture of suicides and other deaths resulting from self-harm in Barnet: ONS, British Transport Police (BTP) and Barnet Enfield and Haringey Mental Health NHS Trust (BEH MHT). In addition an audit of the North London coroner's data was carried out, providing more in depth information about factors that may be associated with suicides and other deaths resulting from self-harm in Barnet. Data on emergency admissions to hospital for self-harm have also been included.

It is important to note that interpretation of death as a suicide varies between organisations meaning that deaths initially investigated as potential suicides may not be classified as such by the coroner following an inquest.

Suicide rates in Barnet

Public Health England (PHE) has calculated age-standardised suicide rates based on the aggregate of deaths over a three year period using ONS data. Averages over three years provide a more accurate reflection of long-term trends as, due to the small numbers involved, annual changes may be a consequence of natural fluctuations[3]. Where the total number of deaths was less than 25, the rate has not been calculated as it would be unreliable[4].

Rates have also been calculated according to age categories, using data aggregated across five years to reduce the impact of random variation[5].

When interpreting trends it is important to note that ONS data reflect the number of deaths registered in a year; the coroner's data reflect the number of deaths that took place in the calendar year.

[3] Local suicide prevention planning: a practice resource (2016) Public Health England http://www.nspa.org.uk/wp-content/uploads/2016/10/PHE_LA_guidance-NB241016.pdf [accessed online 25/1/17]

[4] Suicide Prevention Profile. Public Health England. https://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide/data#page/0/gid/1938132828/pat/6/par/E12000007/ati/102/are/E09000002 [accessed online 25/1/17]

[5] Suicide Prevention Profile. Public Health England. https://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide/data#page/6/gid/1938132828/pat/6/par/E12000007/ati/102/are/E09000002/iid/91390/age/294/sex/1 [accessed online 25/4/17]

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Age-standardised suicide rates

Suicide Rate (age standardised per 100,000) 2013-2015	Barnet (95% CI)	London (95% CI)	England (95% CI)
All	9.3 (7.3-11.5)	8.6 (8.2-9.0)	10.1 (10.0-10.3)
Male	14.2 (10.7-18.5)	13.4 (12.6-14.1)	15.8 (15.5-16.1)
Female	Calculation of the rate would be unreliable due to the low numbers involved[4]	4.1 (3.7-4.6)	4.7 (4.6-4.9)

Table 1. The age-standardised suicide rates per 100,000 population in Barnet, London and England (2013-2015)[4].

The data from 2013 to 2015 show an overall age-standardised suicide rate in Barnet of 9.3 per 100,000 population[4], compared with a rate of 6.8 per 100,000 population (95% CI 5.2-8.7) from 2012 to 2014.[6] The male rate from 2013 to 2015 was 14.2 per 100,000 population[4], compared with 9.0 per 100,000 (95% CI 6.5-12.3) from 2012 to 2014[6]. The rates in Barnet are not statistically significantly different from those in London and England either overall or for males.

The data suggest that there may have been a rise in suicide rates both overall and in males although it is important to recognise that none of these increases are statistically significant and may be due to random variation. Given the low number of female suicides, an overall increase may be driven by an increase in the male rate which is in contrast to the national decline observed in 2015.

[6] London Borough of Barnet Suicide Prevention Report (2016). Barnet Public Health Team.

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Suicide rates in males

Suicide Rate (per 100,000) 2011-2015	Barnet (95% CI)	London (95% CI)	England (95% CI)
10-34 years	6.8 (4.3-10.3)	8.0 (7.4-8.6)	10.5 (10.2-10.8)
35-64 years	14.2 (10.5-18.9)	16.8 (15.9-17.7)	20.8 (20.4-21.2)
65+ years	16.4 (9.7-25.9)	13.1 (11.6-14.7)	12.6 (12.1-13.1)

Table 2. Male suicide rates per 100,000 population according to age categories in Barnet, London and England (2011-2015)[4].

The data show that the suicide rate per 100,000 population is significantly lower in the 35-64 year age group compared with the rate in England[4]. The other groups do not appear to differ significantly from the rates in London and England. The rates equate to 22, 48 and 18 deaths in each of the categories respectively indicating that although the highest rate of suicides was in the 65+ age group, the age category with the highest number of deaths was the 35-64 year olds[4].

Suicide rate in females

The local authority crude mortality rates for females could not be calculated due to the small numbers involved[4].

Suicide Rate (per 100,000) 2011-2015	Barnet (95% CI)	London (95% CI)	England (95% CI)
10-34 years	Calculation of the rate would be unreliable due to the low numbers involved[4]	2.7 (2.3-3.1)	2.9 (2.8-3.1)
35-64 years	Calculation of the rate would be unreliable due to the low numbers involved[4]	5.0 (4.5-5.5)	6.0 (5.8-6.2)
65+ years	Calculation of the rate would be unreliable due to the low numbers involved[4]	5.2 (4.4-6.1)	4.4 (4.2-4.7)

Table 3. Female suicide rates per 100,000 population according to age categories in Barnet, London and England (2011-2015)[4].

Suicide rate in Barnet, Enfield and Haringey

Comparing Barnet with Enfield and Haringey, with whom the borough shares mental health services, the overall age-standardised suicide rate is not statistically significantly different[4]. This pattern is also evident in men.

Suicide Rate (age standardised per 100,000) 2013-2015	Barnet (95% CI)	Enfield (95% CI)	Haringey (95% CI)
All	9.3 (7.3-11.5)	6.9 (5.1-9.0)	10.8 (8.2-13.9)
Male	14.2 (10.7-18.5)	11.0 (7.9-14.9)	18.2 (12.9-24.6)
Female	Calculation of the rate would be unreliable due to the low numbers involved[4]	Calculation of the rate would be unreliable due to the low numbers involved4	Calculation of the rate would be unreliable due to the low numbers involved[4]

Table 4. The age-standardised suicide rates per 100,000 population in Barnet, Enfield and Haringey[4].

Emergency admissions for self-harm in Barnet

PHE has collated data on intentional self-harm serious enough to result in an emergency hospital admission for 2014/2015. The definition of self-harm is intentional self-injury or poisoning, regardless of the motivation or intention to end their life[7]. A history of self-harm, regardless of intent, is the strongest predictor for a person to subsequently take their own life, particularly in those who have multiple hospital presentations following an episode of self-harm[3,8]. A person who self-harms is 50-100 times more likely to die from suicide in the

[7] Public Health Profiles. Emergency hospital admissions for intentional self-Harm. Public Health England. https://fingertips.phe.org.uk/search/self%20harm#page/6/gid/1/pat/6/par/E12000007/ati/102/are/E09000002/iid/21001/age/1/sex/4 [accessed online 24/4/17]

[8] Assessment of suicide risk in people with clinical depression: A clinical guide (n.d.). Centre for suicide research, Department of Psychiatry, University of Oxford. http://cebmh.warne.ox.ac.uk/csr/clinicalguide/riskfactors.html [accessed online 24/4/17]

12 months following the episode of self-harm[9]. Half of those who die from suicide have previously self-harmed, often shortly prior to their death[3].

Table 5 below shows that the rate per 100,000 people in Barnet is just over half the rate in England overall and is not significantly different from that in London[10].

	England (95% CI)	**London (95% CI)**	**Barnet (95% CI)**
Emergency hospital admissions for intentional self-harm: directly age-sex standardised rate per 100,000 **(2014/15)**	191.4 (190.3-192.6)	97.3 (95.1-99.4)	99.0 (89.1-109.6)

Table 5. Age and sex-standardised rates of emergency hospital admissions due to intentional self-harm in Barnet per 100,000 population[10].

Barnet Enfield and Haringey Mental Health Trust Data

Data on serious incidents (SI) were requested from BEH MHT. These include suicides and suspected suicides of patients under the care of the trust or within six months of discharge. Suspected suicides are subject to a Coroner's inquest therefore the number of confirmed suicides is likely to be lower.

	2015 to 2016 (1st April – 31st March	**2016 to 2017 (1st April to 13th February)**
Serious incidents (including suicides and suspected suicides)	65	59
Suspected suicides (as reported on Datix)	20	20

[9] Self-Harm. NICE Guidance (2013) National Institute for Health and Care Excellence https://www.nice.org.uk/guidance/qs34/chapter/Introduction-and-overview [accessed online 24/4/17]

[10] Public Health Profiles. Emergency hospital admissions for intentional self-Harm https://fingertips.phe.org.uk/search/self%20harm#pat/6/ati/102/par/E12000007 [accessed online 24/4/17]

Table 11. Table showing trust-wide numbers of serious incidents and suspected suicides of current or recently discharged BEH MHT patients.

There are clear processes in place at BEH MHT to investigate all SI; these were documented in the 2016/2017 Barnet Suicide Prevention Report[6].

North London coroner's data

Audit

Methodology

The public health team conducted an audit of the North London coroner's data from 2011 to 2015 with the aim of trying to identify local patterns or drivers that could signal areas for targeted intervention. This was the first time such an audit had been carried out. Permission to conduct the audit and access to the data was sought via the coroner's clerk. The audit was carried out by one member of the public health team between November 2016 and March 2017.

Where it is suspected that a person may have taken their own life the death must be referred to the coroner[11]. An inquest will be held to establish the circumstances of the death. This will include understanding how, when and why the person died[12]. The inquest findings are recorded on the coroner's electronic database along with demographic details, post mortem results, medical letters and toxicology results. Data were collected for deaths that received the following conclusions:

- Suicide
- Open verdict
- All other verdicts - where death resulted from self-harm
- Accidental deaths*
- Alcohol/drug related deaths and road traffic accidents*

*Accidental, alcohol/drug related deaths, and road traffic accidents were included only where there was insufficient information available to the auditor to exclude intent. The interpretation was based on the information provided based on narrative provided by the coroner and is quite a subjective process.

The following groups were included in the audit:

- Those who died in Barnet (but may have been resident elsewhere)

[11] When death occurs: which deaths must be reported to the coroner? Manchester City Council http://www.manchester.gov.uk/info/626/coroners/5532/when_death_occurs/2 [accessed online 4/4/17]

[12] Inquest. NHS Choices http://www.nhs.uk/conditions/Inquest/Pages/Introduction.aspx [accessed online 4/4/17]

- Those who attempted to end their life in Barnet (but may have died elsewhere)
- Those who were resident in Barnet (but may have died elsewhere)

The decision was made to include all of these groups because of their relevance to suicide prevention interventions in the borough. Deaths and attempts in the borough can be affected by preventative interventions in public places such as rail and tube stations; and local care pathways and infrastructure will impact on those who are resident in Barnet. No restriction was placed on age.

The audit framework was provided by the Haringey public health team and used with their permission. Key areas of analysis included:

- Age
- Method
- History of mental health problems
- Self harm
- Substance misuse
- Contact with health services
- Place of birth
- Employment

The results of the audit have been shared with the members of the suicide prevention group. Understanding the history of mental ill health and self-harm, potential risk factors (e.g. unemployment, social isolation, debt), and previous contact with services (such as mental health, primary care and drug & alcohol) of people who take their own lives may identify opportunities to learn and improve practice at a local service level. However the numbers are too small to provide a strong enough evidence base for population-level interventions as they cannot provide statistical assurance of trends or associations. Due to the overall small numbers of suicides, annual collection of data is unlikely to be of use. Data could be collected on a three to five-year basis as this would provide stronger evidence of trends. Data collection across Barnet, Enfield and Haringey, or at a London-wide level will provide a stronger basis to inform future interventions. The analysis has raised issues which are being raised with colleagues regionally. Data collection across Barnet, Enfield and Haringey is being explored as is the possibility of future London-wide data collection through the Thrive London programme which is working towards improving mental health across London.

The coroner has agreed to inform the public health team about emerging areas of concern such as suicide clusters associated with a particular method or location. This is an area where the coroner's data would be of value and would support population-level approaches

such as raising awareness of and providing information about suicide and help-seeking behaviour in the community[13].

Barnet suicide prevention meeting of key partners

This year's suicide prevention meeting was held in March 2017 and was attended by partners from Barnet Council, Barnet Clinical Commissioning Group, BEH MHT, Barnet Adult Substance Misuse Service, primary care and North London Samaritans.

The suicide prevention group meets on a twice-yearly basis. Its remit is to:

- Share relevant local data and intelligence to support the understanding of suicides and deaths of undetermined intent in Barnet;
- Develop and implement Barnet's suicide prevention action plan;
- Identify gaps in and opportunities for the suicide prevention work;
- Raise concerns and queries;
- and suggest additional membership as appropriate

The meeting provided an opportunity to present and discuss some of the audit data, review the 2016/2017 suicide prevention action plan and develop new actions for 2017/2018. Discussions resulted in a number of actions being closed, while others were carried over to 2017/2018 plan where partners felt that further work was required. Where an action has been closed but partners would benefit from updates on that area of work, these will be provided at subsequent meetings. The minutes from the meeting have been included in appendix 1 of this report, incorporating areas that require further exploration. An update meeting will be held in September 2017 and these areas will be reviewed to determine whether additional actions should be added to the plan.

[13] Identifying and responding to suicide clusters and contagion: a practical resource (2015). Public Health England https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/459303/Identifying_and_responding_to_suicide_clusters_and_contagion.pdf [accessed online 1/6/17]

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Actions have been categorised into a number of strategic themes:

- Communications
- Accessibility
- Pathways
- Stigmatisation
- Data
- Workforce

These were devised by partners during the 2016 suicide prevention meeting with the aim of providing a clear framework for the action plan.

Update on the 2016/2017 Action Plan

Strategic theme/s	Agreed action	Lead partner/s	Progress/Timescale	Outcome
Communications	**To clarify the processes around BTP referrals to the local authority of individuals considered to have needs under the Care Act.**	BTP	Clarified that referrals for people with needs under the Care Act are now working as they should; they are appropriately being sent through Social Care Direct. Referrals are of those who have been detained under a Section 136 by BTP or have received a BTP suicide prevention plan.	Action closed but work to be done by public health (PH) to understand concerns that inappropriate referrals are being made to Social Care Direct and BEH MHT by the Metropolitan Police.
Accessibility	**For the Joint Commissioning Unit (JCU) to review bereavement services.**	Paula Arnell/PH	The PH team has worked with the JCU to develop specific support by Barnet Bereavement Services for those	Action closed but updates will be provided to the group as the new

			bereaved by suicide.	service develops.
Pathways, Stigmatisation	**Barnet Voice to be put in touch with the council representative who deals with freedom passes to understand problems around the renewal of freedom passes for people with mental health problems, including why evidence from GPs is not being accepted; and determine how to address this.**	PH	Freedom Pass Renewals Improvement Group set up to review the process of issuing Freedom Passes. Identified that people with mental health problems were previously assessed in their own category which was not in line with the Department for Transport guidance. Now assessed under the category 'refused a licence, other than on grounds of persistent misuse of drugs or alcohol'. Recognised that this will exclude some people who had previously been eligible. Pass holders will be contacted three months before passes expire and will have the opportunity to appeal. GP evidence can be accepted for this category.	Action closed.
Communications	**Online safety work to be discussed with the Safer Communities Team.**	PH	An article on cyber-bullying, self-harm and suicide with tips for teachers was included in the school circular on 8th of February as part of Safer Internet Day and Children's	Action ongoing and carried over to 17/18 plan.

			Mental Health Week. The PH team is working with the communications department to circulate an article on cyberbullying, self-harm and suicide for parents. An online safety subgroup of the Barnet Safeguarding Children Board has been set up to strategically develop online safety work in Barnet. Work is taking place on an online safety award for primary schools.	
Communications	**For Barnet Voice and PH to revisit the production of resources on Barnet Voice's support services.**	PH/Barnet Voice representative	To be included in the Barnet community directory	Action closed
Pathways	**BTP and drug & alcohol services to communicate regarding alcohol and drug-related incidents on the railways, to identify entry into care pathways.**	Bridget O'Dwyer and BTP	Drug & alcohol services have followed up with BTP. There is an intention for joint working going forward, with BTP being able to signpost to drug and alcohol services.	Action closed but updates on the work between BTP and the drug & alcohol services to be provided at subsequent meetings.
Pathways	**The CCG to discuss the development of a framework for practices to analyse suicides and ensure sharing**	CCG	PH has carried out an audit of the coroner's data from 2011-2015. Access to certain information (e.g. last contact with primary care) was	Action carried over to the 17/18 plan and will involve the development of a template

	of good practice		limited which reduces the ability to draw reliable conclusions. The Coroner has agreed to update PH on relevant emerging areas of concern (e.g. new methods of suicide).	to collect data following SI involving patients under the care of General Practice. The national significant event audit guidance can be used to support this.
Accessibility, Pathways	**The CCG to discuss progress on auditing crisis and community services for patients readmitted to crisis services**	CCG	Action has been discussed with the CCG and plans are in place for commissioners in Barnet, Enfield and Haringey to complete a service review/service development plan of the Crisis Resolution and Home Treatment Team services by January 2018.	Action carried over to the 17/18 plan.
Pathways	**To look into the quality of accommodation that patients are discharged into.**	Housing Strategy Group	A weekly discussion takes place between the Trust/CCG and senior social care managers across Barnet, Enfield and Haringey regarding patients ready for discharge. For Barnet patients who receive a package funded by social care, a Brokerage Team will assist the allocated worker to find suitable accommodation, meeting eligible	Action closed.

			needs under the Care Act 2014. A joint housing and social care group considers referrals for housing through Barnet Homes where support is also required. If there is a continuing health care need the CCG will assess for a CHC funded placement or package of care.	
Workforce	**Adult Social Care to consider options for suicide prevention training for staff.**	PH	Adult Social Care staff undertook the self-harm and suicide prevention training commissioned by PH. Family Services are commissioning suicide prevention for their staff as part of the 'Child A' action plan.	Action closed but updates will be provided at future meetings.
Workforce	**PH to liaise with BEH MHT to create a resource for GPs and other healthcare professionals to support them to manage people with self-harm and suicidal ideation.**	BEH MHT	BEH MHT has agreed to develop a resource to support healthcare professionals.	Action ongoing and carried over to the 17/18 plan.

Appendix 2

2017/2018 Suicide Prevention Action Plan

The actions for the 2017/2018 plan have been developed based on local priorities, findings from the audit and the national suicide prevention strategy[19].

Strategic theme/s	Agreed action	Lead partner/s	Timescale
Communications	**To develop e-safety work in Barnet through the Barnet Children Safeguarding Board (BCSB) e-safety subgroup, ensuring strategic engagement with schools and parents.**	PH/BCSB e-safety subgroup.	Ongoing with a further meeting in July 2017
Data	**To develop a template to enable data collection following significant events, including suspected suicides and suicide attempts, involving patients under the care of General Practice.**	PH/Charlotte Benjamin	September 2017
Accessibility, Pathways	**Barnet, Enfield and Haringey commissioners to complete a service review/service development plan of the Crisis Resolution and Home Treatment team by January 2018.**	Enfield CCG	January 2018
Workforce	**BEH MHT to create a resource for GPs and other**	BEH MHT	September 2017

	healthcare professionals to support them to manage people with self-harm and suicidal ideation.		
Workforce	**BEH MHT to work with Primary Care to develop and deliver suicide prevention training for GPs.**	Charlotte Benjamin/BEH MHT	September 2017
Workforce	**To liaise with the DWP for BEH MHT to review their 'six point plans' and provide training to DWP staff to support the implementation of the plans.**	PH/BEH MHT/DWP	To revisit with DWP by November 2017
Communications	**To raise concerns about irresponsible reporting of deaths resulting from self-harm with Samaritans as these occur; and engage with the local media where appropriate to ensure that deaths are reported in line with the Samaritans media guidelines.**	PH	Ongoing
Pathways	**To understand the care pathway for people who present to A&E with self-harm, suicidal ideation or suicide attempts.**	PH	September 2017

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Pathways	**To understand the care pathway for people who present to the London Ambulance Service with self-harm, suicidal ideation or suicide attempts.**	PH	September 2017
Workforce	**To liaise with relevant partner organisations (e.g. Barnet Homes, older people's services) to ascertain training needs around identifying suicide risk.**	PH	March 2018
Workforce	**To work with relevant partners to understand schools' needs around suicide prevention; and to develop a suicide prevention pathway for schools and partners, linking with the Resilience and Healthy Schools programmes.**	PH	March 2018
Data	**PH to raise the possibility of collecting data at a BEH and London-level to explore suicide rates in migrant populations and according to occupation status with relevant colleagues.**	PH	September 2017

Appendix 2

Correlation with the national strategy

Barnet has already implemented, and plans to implement a number of actions that support the national strategy. These are summarised below.

National priority area(s)[19]	Barnet action(s)
Providing better information and support to those bereaved or affected by suicide	The PH team has worked with commissioners to develop specific bereavement support for those bereaved by suicide.
Tailoring approaches to improve mental health in specific groups: • **Children and young people** • **Users of drug and alcohol services** • **Perinatal mental health** • **People in receipt of employment benefits** • **Lesbian, gay, bisexual and transgender; black and minority ethnic; people with long-term conditions and people with untreated depression**	PH commissioned self-harm and suicide prevention training for staff working with children and young people. Family services are to commission suicide prevention training for social workers. An Online Counselling and Support Service for 11-25 yr olds has been commisioned and is currently being promoted across Barnet Schools A Resilient Schools Programme led by Public Health has been launched in the first 6 Barnet schools and a coordinator has been appointed. A new Emotional Wellbeing Team has been established in Barnet Council funded by Health Education England to support low/moderate anxiety/depression in young people who do not meet the CAMHS threshold of need. M.A.C UK/Reach is a new project in the process of setting up with the council to go live working with gang members and hard to reach individuals with mental health and high risk behaviours Barnet's Adult Substance Misuse Service and BTP are to work jointly to facilitate signposting of people involved in drug and/or alcohol-related events on the railways into drug and alcohol services. To engage strategically with schools and parents around e-safety through the BCSB e-safety subgroup. To work with relevant partners to understand schools' needs around suicide prevention; and to

	develop a suicide prevention pathway for schools and partners, linking with the Resilience and Healthy Schools programmes. The PH team is to liaise with the Department of Work and Pensions regarding training from BEH MHT to support staff to implement six point plans. To liaise with relevant partner organisations (e.g. Barnet Homes, older people's services) to ascertain training needs around identifying suicide risk.
Supporting research, data collection and monitoring	The PH team has audited the North London Coroner's data from 2011-2015 to identify areas for potential intervention. PH and primary care are to work together to develop a template to enable data collection following significant events, including suspected suicides and suicide attempts, involving patients under the care of General Practice.
Reducing the risk of self-harm as a key indicator of suicide risk **Reducing the risk of suicide in high risk groups**	BEH MHT are to develop a resource for GPs and other healthcare professionals to support them to manage people with self-harm and suicidal ideation. BEH MHT is to work with Primary Care to develop and deliver suicide prevention training for GPs. To understand the care pathway for people who present to the London Ambulance Service with self-harm, suicidal ideation or suicide attempts. To understand the care pathway for people who present to A&E with self-harm, suicidal ideation or suicide attempts. Barnet, Enfield and Haringey commissioners to complete a service review/service development plan of the Crisis Resolution and Home Treatment team by January 2018.
Supporting the media in delivering sensitive approaches to suicide and suicidal behaviour	To review local news stories reporting on deaths from self-harm and raise any concerns with Samaritans to ensure that deaths are being reported responsibly.

Conclusion

The 2017/2018 report and action plan, which will be presented to the Health and Wellbeing Board in July 2017, shows clear areas of progress since 2016/2017 (e.g. development of a targeted approach to supporting people bereaved by suicide, an audit of the coroner's data).

Consideration must be given to how the coroner's data should be used going forward. The small number of deaths at a borough-level does not provide sufficient statistical assurance on which to base population-level interventions. Where it may be of particular value however is through the support of learning and improvement in local services; and in the identification of suicide clusters and contagion. Going forward there should be exploration of data collection at the level of Barnet, Enfield and Haringey, or across London which would provide a stronger evidence base for population-level interventions.

It is important that partners take responsibility for their actions, and any difficulties achieving what is required should be brought to September's suicide prevention update meeting for discussion with the group. Where the group or responsible partner feels that an action that was previously agreed can no longer be achieved, a decision must be made as to whether to remove that action from the plan.

Proposals are being put forward for a BEH MHT suicide prevention strategy or plan; the Barnet Public Health team will be participating in the development of this work. This will support staff and carers following a suicide, and implement the recommendations for secondary care from the National Confidential Inquiry into Suicide and Homicide which will support local suicide prevention efforts.

Appendix 1

Methodology for coding deaths by suicide

To get an understanding of the coding process a discussion was held with a Senior Research Officer at the Office for National Statistics (ONS). The ONS defines suicide as all deaths from intentional self-harm for persons aged 10 and over, and deaths of undetermined intent in those aged 15 and over. Further detail on the coding of deaths by the ONS is included in appendix 1.

Deaths of undetermined intent are those that result from self-harm (e.g. poisoning) but where there is insufficient evidence to suggest that the person intended to end their life. The ONS codes suicide deaths under the following ICD-10 (International Classification of Diseases) categories:

- Intentional self-harm
- Injury/poisoning of undetermined intent

Coding is based on the information obtained from the Coroner's office. This information includes not only the Coroner's conclusion but the circumstances surrounding the death. Deaths are included or excluded in the ONS statistics as follows:

Coroner's conclusion	**Inclusion in the ONS data**
Suicide	Yes
Open	Yes
Accident/misadventure	No, but some drug deaths fall into the category of misadventure and would be included if there was insufficient evidence to exclude intent.
Alcohol/drug related	Possibly, if there was insufficient evidence to exclude intent.
Road traffic accidents	No
All other verdicts	Yes, where death resulted from self-harm.

Appendix 2 delete

The table below shows the breakdown of individuals who died in and were residents of Barnet by country of birth, and the suicide rate in each group.

Country of birth	**No. of people in the audit population who died in Barnet and were resident in Barnet (2011-2015)**	**Percentage of the audit population (2011-2015)**	**No. of Barnet residents according to country of birth (2011)**	**Suicide rate per 100,000 (95% CI) 2011-2015**
UK (England, Northern Ireland)	65	48.9%	212,496	6.1 (3.3-10.5)
Western Europe (Republic of Ireland, Spain, Germany, France)	8	6.0%	11,252	14.2 (1.0-57.0)