

Suicide Prevention Report in Barnet: A report to the Health Overview Scrutiny Committee – December 2017

Purpose of Report

In April 2016, the Commons Health Select Committee published a national enquiry into suicide prevention¹. The enquiry report concluded that whilst the government strategy is essentially sound, it is felt that it has been inadequately implemented by local areas. It included a number of recommendations as presented in Appendix 1. These included the suggestion that local scrutiny committees should be involved in ensuring effective implementation of local suicide prevention plans.

This report provides an overview of suicide prevention work in Barnet to date ahead of the annual refresh of local actions.

Introduction & Background

Suicide is preventable. Yet since 2007 rates in England have increased, making suicide the biggest killer of men under 50 as well as a leading cause of death in young people and new mothers. The death of someone by suicide has a devastating effect on families, friends, workplaces, schools and communities, as well as an economic cost.

The cross-government National Suicide Prevention Strategy² for England was published in 2012 and progress was reviewed in January 2017³. The strategy aims to reduce the national suicide rate by 10 per cent by 2020/21. This ambition was echoed in the NHS's Five Year Forward View⁴.

The 2012 National Strategy committed to tackling suicide in six key areas for action, with the scope of the strategy later expanded to include a further key area, addressing self-harm:

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;

¹ <https://publications.parliament.uk/pa/cm201617/cmselect/cmhealth/1087/108702.htm>

² <https://www.gov.uk/government/publications/suicide-prevention-strategy-for-england>

³

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/582117/Suicide_report_2016_A.pdf

⁴ <https://www.england.nhs.uk/five-year-forward-view/>

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.

In January 2015, The All Party Parliamentary Group (APPG) on Suicide and Self-harm published an “Inquiry into Local Suicide Prevention Plans in England”⁵. The APPG considered that there were three main elements that are essential to the successful implementation of the national strategy for suicide prevention.

The report states that all local authorities must have in place:

- Suicide audit work to understand local suicide risk
- A suicide prevention plan in order to identify the initiatives required to address local suicide risk
- A multi-agency suicide prevention group to involve all relevant statutory agencies and voluntary organisations in implementing the local action plan.

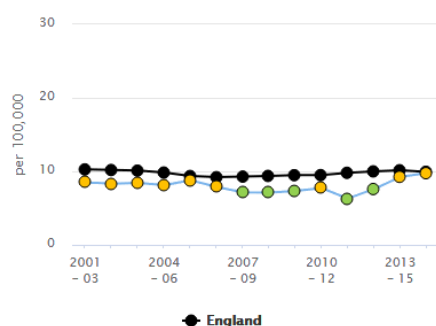
Barnet Public Health initiated a multi-agency working group to create a suicide prevention plan in 2014. It brought together a range of local partners including representatives from the CCG, Coroner’s office, Police, Ambulance services, NHS, Children’s and Adult Social Care, Network Rail, and the Voluntary and Community Sector. The group provides a platform for partners to share intelligence, identify and review local suicide prevention activities, to explore opportunities for future collaboration between the partners and agree actions.

The Barnet Suicide Prevention Report and Action Plan were completed in March 2015 and have been refreshed annually. The 2017 report was presented to the HWBB in July 2017 along with a briefing on the Mayor of London’s Thrive programme. Thrive identifies suicide prevention as one of the priority areas for action on mental health in the capital along with understanding of mental health, community resilience, targeted prevention for children and young people and employment support. The report also summarised the audit of suicides that was completed in 2017 after access to coroner’s records was secured.

Suicide in Barnet

The most recent Barnet Suicide prevention report presents ONS data available from 2016 and reflects the deaths that were registered in that year rather than those that took place in the year.

⁵ <http://www.samaritans.org/sites/default/files/kcfinder/files/APPG-SUICIDE-REPORT.pdf>



Recent trend: -

Period	Count	Value	Lower CI	Upper CI	London	England
2001 - 03	71	8.5	6.6	10.8	10.1	10.3
2002 - 04	68	8.3	6.4	10.6	10.0	10.2
2003 - 05	69	8.4	6.5	10.7	10.0	10.1
2004 - 06	66	8.1	6.2	10.4	9.7	9.8
2005 - 07	74	8.8	6.9	11.1	9.2	9.4
2006 - 08	67	7.9	6.1	10.1	8.8	9.2
2007 - 09	63	7.1	5.4	9.2	8.5	9.3
2008 - 10	64	7.1	5.4	9.1	8.5	9.4
2009 - 11	69	7.3	5.7	9.3	8.4	9.5
2010 - 12	71	7.7	6.0	9.8	8.4	9.5
2011 - 13	58	6.3	4.8	8.2	8.0	9.8
2012 - 14	68	7.6	5.9	9.7	7.8	10.0
2013 - 15	84	9.3	7.3	11.5	8.6	10.1
2014 - 16	91	9.7	7.8	12.0	8.7	9.9

Source: Public Health England (based on ONS source data)

The data show a slight increase in the rate of suicides in Barnet (for those aged 10 and over) from 9.3 per 100,000 (95% CI 7.3-11.5) population in the period 2013-15 to 9.7 per 100,000 (95% CI 7.6-12.0) in the period 2014-16, although this is not statistically significant. Whilst the Barnet rate is higher than London and lower than England, the difference is not statistically significant.

The rate for males in 2014-16 was 15 per 100,000 and for females 5 per 100,000. As for all people, these rates are not statistically different to London or England and reflect national trends.

Comparing Barnet with Enfield and Haringey, with whom the borough shares mental health services, the overall age-standardised suicide rate is not statistically significantly different⁶.

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	Calculation of the rate would be unreliable due to the low numbers involved	Calculation of the rate would be unreliable due to the low numbers involved

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

⁶ 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>

Barnet Suicide Prevention Group

Suicide prevention is the shared responsibility of a wide range of agencies. The borough action plan is the product of the Barnet multi-agency suicide prevention group. Partners' commitments and delivery of those actions is the responsibility of the respective partners. A six monthly progress review meeting is held to identify any delivery issues.

Early work by the Suicide Prevention Group identified the need to undertake a suicide audit for Barnet to provide more detailed intelligence on the factors affecting suicide in Barnet. The aim of the audit was to increase understanding of local suicide data and patterns in order to shape local decisions and priorities around suicide prevention.

An audit was carried out based on data gathered from files available from the local HM Coroner's Office. Records were accessed for all Barnet residents who had received a Coroner's verdict of suicide, open verdict, alcohol/drug related where there was evidence of intent, self-harm related.

Results of the audit indicated that demographic trends were consistent with those reported nationally. Whilst there were suggestions of potentially higher rates amongst certain groups, numbers were too small to allow us to determine if these were statistically significant differences or might be the result of random variations.

Circumstances of suicide were also consistent with those observed nationally with hanging the most common method of suicide followed by rail fatalities. The audit also provided information on risk factors and contact with services prior to suicide. It found:

- 51% had a history of mental health problems
- 21% had a history of self-harm
- 14% had a history of substance use. Of which 72% had a co-morbid mental health condition
- 42% were known to have been seen by mental health services within seven days prior to their death
- Almost a quarter had been in contact with their GP within one week prior to death

It should be noted however that on many records, there was an absence of medical history and substance misuse history. This makes it impossible to conclude whether these individuals had no history or whether the information was missing.

Understanding the history of mental ill health and self-harm, potential risk factors and previous contact with services of people who take their own lives may identify opportunities to learn and improve practice at a local service level. However, the Barnet audit has shown that the numbers are too small to identify clear trends or associations beyond what could reasonably be expected through random variation.

Data collection across Barnet, Enfield and Haringey, or at a London-wide level would offer stronger analysis to appropriately direct interventions and is being explored.

Local Suicide Prevention Actions:

Achievements in delivery of previous Action Plans include:

- The referral pathway from British Transport Police into the local authority for people with needs under the Care Act 2014 was clarified;
- Specific support for people bereaved by suicide has been commissioned and is being delivered by the Barnet Bereavement Service;
- The local position on freedom passes for people with mental health conditions was clarified;
- A pathway into substance misuse services from the British Transport Police was established;
- A process was established for reviewing the suitability of accommodation for patients with support needs being discharged;
- Self-harm and suicide prevention training was delivered to Adult Social Care Staff;
- Samaritans engaged with local press to ensure responsible reporting.

The Action Plan for 2017-18 was agreed in March 2017 and reviewed in September. Progress against this plan can be seen in **Appendix 2**. Delivery to date has mostly been to plan with many items completed.

The Plan includes:

- Improving the way in which suicides are reported on by local press
- Improving learning in general practice from suspected suicides and suicide attempts
- Developing e-safety work, ensuring strategic engagement with schools and parents
- Understanding suicide prevention guidance for children & young people
- Supporting DWP to implement their 'six point plan' for suicide prevention
- Improving workforce knowledge regarding suicide prevention

The plan aligns with national guidance and includes many of the recommendations highlighted by the Commons Health Select in their national enquiry. Based on recent policy and literature, new priorities are likely to include:

1. More attention to Children & Young People, in particular reviewing:
 - a. suicide prevention pathways for schools
 - b. support for young people who are bereaved by suicide
 - c. specific support for vulnerable groups including LGBT and looked after children (LAC)
 - d. mental health in colleges and universities

- e. self-harm amongst young people
- 2. Self- Harm
 - a. Developing a pathway for patients who present at A&E with self-harm
- 3. Identifying sources of support for people vulnerable to suicide
 - a. Ensuring all relevant services are recorded on the Barnet Community Directory
 - b. Ensuring services are promoted locally, particularly to those less likely to access traditional services
 - c. To ensure that impacts on people vulnerable to suicide are considered in health impact assessments
 - d. Working with partners to identify a way that those bereaved by suicide can receive a copy of “Help is at Hand” within 48 hours, but where possible, when contact is first made with the family/friend of the deceased individual.
- 4. Working with CCG commissioning leads for Mental Health to:
 - a. Understanding the inpatient discharge process and ensuring 3 day follow up
 - b. Review the offer for patient accessing IAPT who are experiencing suicidal ideation
- 5. Further exploring opportunities for suicide prevention at a London level
 - a. Supporting the Thrive LDN suicide prevention work which includes developing a co-ordinated system for reporting data from coroners and other sources (such as the police) that could act as an early warning system.

Challenges and Next Steps:

Whilst there has been progress in a number of areas within the Barnet Suicide Prevention Plan there can be challenges in securing engagement from partners. This is not exclusive to Barnet and is echoed by other areas.

Having said this, there have been a wide range of partners engaged to date with a number of positive outcomes. The annual suicide prevention plan is due for review in March 2018, at which time new opportunities will be explored with partners and priorities will be set for 2018/19.

Appendix 1: Recommendations from Commons Health Select Committee national enquiry into suicide prevention⁷

Implementation

1. We welcome the Secretary of State’s promise that the Government “will put in place a more robust implementation programme to deliver the aims of the

⁷ <https://publications.parliament.uk/pa/cm201617/cmselect/cmhealth/1087/108702.htm>

National Strategy as recommended by the HSC [Health Select Committee]” and we urge him to publish details of the implementation programme as soon as possible.

Quality of local authorities’ plans

2. We welcome the fact that 95 per cent of local authorities have a suicide prevention plan in place or in development. However we are concerned that there is currently no detail about the quality of those plans. It is not enough simply to count the number of local authorities which report that they have a plan in place.
3. It is essential that there is a strong and clear quality assurance process to ensure that local authorities’ plans meet quality standards. This will also enable more support to be provided to local authorities where it is needed. In its response to this report, the Government should set out how the quality assurance process will work; who will be responsible for it; how it will report; how often it will be carried out; and when it will start.
4. We recommend that Public Health England’s suicide prevention planning guidance for local authorities should be developed into quality standards against which local authorities’ suicide prevention plans should be assessed.
5. We consider that oversight of nationwide implementation [of local authorities’ plans] could usefully be carried out by an implementation board, as recommended by Samaritans and Hamish Elvidge (Chair of the Matthew Elvidge Trust (a trust aiming to tackle the issue of depression in young people) and the Support after Suicide Partnership). As well as ensuring implementation of local authorities’ plans, the implementation board should have responsibility for overseeing the implementation of the other aspects of the Government’s suicide prevention strategy.
6. We recommend that health overview and scrutiny committees should also be involved in ensuring effective implementation of local authorities’ plans. This should be established as a key role of these committees. Effective local scrutiny of a local authority’s suicide prevention plan should reduce or eliminate the need for intervention by the national implementation board.
7. The Government should consult the National Suicide Prevention Strategy Advisory Group on whether the implementation board should also be responsible for the quality assurance process of local authorities’ plans, or whether that responsibility should rest with another body. (Paragraph 30)

Funding

8. We welcome the provision of funding for suicide prevention guaranteed for 2018/19–2020/21. However, unless it is supported by other funding already committed by the Government to mental health, and unless that funding actually reaches the front line, we are concerned that it will not be sufficient to fund the suicide prevention activity required both to meet the Government's target of a 10 per cent reduction in suicides and to implement the strategy.
9. We note that there are currently important steps which could be taken to reduce suicide but which cannot be acted upon due to the lack of significant additional resource. The Government should make a clear commitment to assuring the funding for every action outlined in the suicide prevention strategy. In order to demonstrate this commitment, the Government should make an estimate of the cost of each activity referred to in the strategy, and indicate what funding is currently allocated to each. This will allow the funding gaps to be identified and addressed.
10. The Government must make clear who has overall responsibility in each area (whether that is the CCG, the director of public health, or another body) to ensure that the money is allocated in the right places within the area to fund both NHS initiatives and public health activity. The Government should set out how the additional funding will be distributed and accounted for so that local authorities and CCGs can plan their suicide prevention work effectively. If there is insufficient funding, the Government should be realistic about what is achievable on existing resources and set out the evidence on prioritising resources.

Services to support people vulnerable to suicide

- **People not in contact with any health services**

11. We recommend that local authorities keep and maintain a record of services of a suitable standard (both in the voluntary sector and commissioned services) to which individuals can be signposted for both practical and emotional support. Part of the work of health overview and scrutiny committees in scrutinising local authorities' suicide prevention plans should be ensuring that these records are created and maintained. There should also be an annual review of the impact of any loss of these services.
12. Local authorities should promote a joined-up, multi-agency collaborative approach to suicide prevention to improve data sharing and knowledge between different sectors which will ultimately lead to more efficient and effective action on preventing suicide.
13. We recommend that organisations and services at high risk locations, including the police and Network Rail (as well as other organisations such as

the RNLI where appropriate), should be involved in the development and implementation of local authorities' suicide prevention plans.

14. We recommend that local authorities should include in suicide prevention plans a strategy for how those who are at risk of suicide but are unlikely to access traditional services will be reached. This should include up-to-date knowledge about what services are available in the voluntary sector.

- **People in contact with primary care services**

15. We recommend that the GMC should ensure that all undergraduate medical students receive training in the assessment of suicide risk as well as depression. We also recommend that the Royal College of General Practitioners and Health Education England should include the assessment of depression and suicide risk in the training and examinations for GPs. The Government should monitor progress on the addition of these competencies to medical school and Royal College exams.
16. Strong and coordinated national leadership is required to ensure that GPs and primary care nurses receive adequate ongoing training in detecting suicide risk. We recommend that NICE guidelines and other training resources should be promoted and made readily available for practitioners by Public Health England and Health Education England. There should be national oversight by Public Health England to ensure that all practitioners involved in the assessment of those who could be at risk of suicide are accessing this training.

- **Drug treatments and suicide**

17. We urge the Government to ensure that NICE guidelines on the appropriate use of drug treatments for depression are promoted and implemented by clinicians.

- **People under the care of specialist mental health services**

18. We repeat our recommendation that all patients being discharged from inpatient care should receive high quality follow up support within three days of discharge. We recommend that this should be in addition to a further instance of follow up support within the first week post-discharge. The Government must ensure sufficient funding for crisis resolution home treatment teams to ensure that they have enough resource to provide adequate support.

19. We urge the Government to ensure that there are enough trained staff to establish and sustain liaison psychiatry services in every acute hospital.
20. More broadly, the Health Education England Mental Health workforce strategy must set out what the Government is going to do to ensure that there are enough trained staff to implement the Mental Health Taskforce recommendations.
21. We welcome the Government's expansion of the Improving Access to Psychological Therapies (IAPT) programme. However we urge the Government to ensure that it is properly integrated into mental health teams supporting people with complex mental health conditions, to ensure that patients being supported by the IAPT programme who experience suicidal ideation can be supported effectively and quickly.

- **Self-harm**

22. All patients who present with self-harm must receive a psychosocial assessment in accordance with NICE guidelines. Patients who present at A&E with self-harm should have a safety plan, co-produced by the patient and clinician, and properly communicated and followed up. We urge the Government to set out its plans for ensuring that the workforce is sufficient to meet these objectives.

Confidentiality and consent

23. We are disappointed that the Government has not included any proposals for action on the Consensus Statement in its report on the strategy. We recommend that there should be a named responsible individual within Government to support the NSPSAG in discussions with the Royal Colleges and to ensure progress in raising awareness of the Consensus Statement and training of staff in this area (including training on how to seek consent).
24. We recommend that further discussions between the NSPSAG and the Royal Colleges on the Consensus Statement should involve representatives from trust legal departments, legal authorities and defence unions, in order to ensure consistent guidance.
25. Training for medical staff on the Consensus Statement and on how to seek consent should include educating medical professionals on the importance of action when a patient has given consent for information to be shared with a friend or family member.

Support for those bereaved by suicide

26. We recommend that ensuring high quality support for all those bereaved by suicide should be included in all local authorities' suicide prevention plans. Bereavement support should be a key criterion on which local authorities' plans are quality assured.
27. We recommend that those bereaved by suicide should receive a copy of 'Help is at Hand' within a maximum of 48 hours, but where possible when contact is first made with the family/friends of the deceased individual. Further support, including information about counselling but also support for the practical problems that bereaved individuals will face (including coroners' inquests and incident reviews), should be offered as soon as is practicable. The next of kin should have access to a victim liaison officer to support them through the inquest.

Media

- **Guidelines for responsible reporting of suicide**

28. We note the lack of detail [in the third progress report] on the action that may be taken if concerns [about irresponsible media reporting of suicide] are escalated to PHE and we recommend that PHE should include options for action in its partnership agreement with Samaritans.
29. We urge the Department of Health and Public Health England to be vocal and proactive in their support for the work ensuring responsible reporting of suicide. We recommend that there should be a nominated person within the Government/Public Health England who is ultimately responsible for ensuring that the Government has a firm grasp of the current media situation and for supporting Samaritans and other organisations and individuals in their work with the media.
30. A clear message must be sent to the media that the Government supports Samaritans' media guidelines and the work that Samaritans do in helping journalists report suicide responsibly.

- **Local media**

31. We recommend that when producing and updating suicide prevention plans, local authorities should include work with local media to ensure good practice in local media sources and to ensure timely follow-up discussions when a guideline has not been followed.

- **Regulation**

32. We recommend a change to the IPSO Editors' Code of Practice to replace the term "excessive detail" with "unnecessary detail".

33. We recommend that the Ofcom Broadcasting Code should be strengthened to ensure that detailed description or portrayal of suicide methods, including particular locations where suicide could be easily imitated, are not permissible.

- **Social media and the internet**

34. We recommend that the Government should clearly set out its expectations of social media companies and relevant stakeholders relating to processes for dealing with harmful content on social media. There should be responsibility within Government for ensuring that these organisations have robust processes in place and for monitoring adherence to the processes.

35. We note the research projects relating to the online environment, in which Samaritans are involved. We urge the Government to closely examine the findings of that research and to report back to us on the action that it proposes to take as a result.

Data

- **Standard of proof**

36. We recommend that the standard of proof for conclusions of death by suicide should be changed to the balance of probabilities rather than beyond reasonable doubt.

- **Coroners' conclusions**

37. We recommend that the Chief Coroner should be given adequate resourcing to allow clear oversight of the variation in the recording of suicide. We also recommend mandatory training for all coroners, both those already in post and newly appointed, on the use of short form and narrative conclusions, to ensure consistency across England and Wales.

38. We suggest that the Government should explore whether information about lethal methods of suicide could be made available to statistical agencies and public health teams, but withheld from public view.

39. We recommend that training for coroners on suicide should include the importance of including sufficient detail in a narrative conclusion about the deceased individual's intent and method used in order to minimise the number of hard-to-code narrative conclusions. Accurate data is crucial to the understanding of what approaches work best in reducing suicide. We suggest that this training could be given by experts in the field of data and suicide prevention.

40. We recommend that training and guidance for coroners should include material about the importance of timely information sharing with public health and mental health teams where appropriate in order to identify possible clusters and the proliferation of emerging new methods of suicide.

Suicide Prevention Plan 2017-18 - Reviewed in January 2018

Action & Topic Area	Lead partner/s	Status & timescale	Progress	Closed
Communications				
1. To raise concerns about irresponsible reporting of deaths resulting from self-harm in the local press 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 Green	<i>Monitoring action</i>	N/A
Pathways and access				
2. To understand the care pathway for people who present to A&E with self-harm, suicidal ideation or suicide attempts.	PH/CCG	March 2018 Amber	Contact has been made with Urgent Care Lead for CCG who is exploring with Royal Free Trust how this can be taken forward.	
3. 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 Amber	The outcomes of the local audit have been shared at London level via the Thrive London Suicide Prevention group. A London approach to data collection is being considered by Thrive. This will take some time to deliver and a schedule is expected to	

			be delivered by Thrive London.	
4. BTP and drug & alcohol services to communicate regarding the alcohol and drug related incidents on the railways to identify entry into care pathways.	WDP and BTP	Carried over from 16/17 – to be resolved ASAP Amber	WDP have fed back that BTP's preference is to refer to their local provider in Westminster who would refer the case on. WDP report that this is not effective so discussions have been reopened with the aim to agree a direct referral pathway into Barnet services. Schedule to be agreed with BTP by Feb 2018.	
5. 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 Amber	The CCGs GP lead and Mental Health Commissioner are reviewing an example template. For consideration at annual review meeting.	
6. Barnet, Enfield and Haringey MH CCG commissioners to complete a service review/service development plan of the Crisis Resolution and Home Treatment team by January 2018.	Enfield CCG	January 2018 Amber	In progress following appointment of a new MH lead in December 17. For consideration at annual review meeting.	
7. 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 LCSB e-safety subgroup	Nov 2017 Green	The LSCB have merged the e-safety work into the Digital Resilience Workstream under the Resilient Schools Programme. A Digital Resilience Award is being rolled out to the pilot primary schools. This will	

			incorporate online safety and online healthy indicators. The Digital Resilience Award has 3 levels: bronze, silver, gold award for schools. It is also being expanded to be appropriate to Secondary and SEND schools.	
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.	Public Health/ Mental Health Priority Group	March 2018 Green	<p>PH presented the annual CDOP report to the Safeguarding Executive Board and the findings from the suicide cases over the past 3 years.</p> <p>The Safeguarding Executive Board has agreed to carry out a thematic review into school-based support for Self-Harm and early indicators of suicidal thoughts. There will be an independent chair with support from PH.</p> <p>The ToRs will be agreed by the Executive Group at the February meeting. The review will commence immediately and conclude by July 2018.</p> <p>HLP recently produced suicide prevention guidance for children & young people, including recommendations for schools on developing suicide prevention pathways which we intend to review in the year ahead.</p> <p>We also plan to ensure alignment with the Resilience and Healthy Schools programmes</p>	

			as that programme develops.	
8. Workforce				
9. 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	September 2017 Amber	Awaiting BEH feedback on progress.	
10. BEH MHT to work with Primary Care to develop and deliver suicide prevention training for GPs.	Charlotte Benjamin/BEH MHT	September 2017 Green	Training delivered at GP conference in Sept 17. Future plans to be considered at annual review.	
11. 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 in 2018 Amber	DWP had no capacity in 2017 due to implementing the benefit changes. This action will be revisited in the annual review meeting.	
12. 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 Amber	Underway. Training plan to be delivered by March.	