PUBLIC

Item Number 7 (u)

DERBYSHIRE COUNTY COUNCIL

CABINET

21st January 2014

Report of the Director of Public Health

DERBYSHIRE ANNUAL SUICIDE AUDIT

(Health & Communities)

1. Purpose of the Report

To inform Cabinet of the results from a review of the annual Derbyshire suicide audit and to make proposals to cease the production of an annual audit of suicide deaths in Derbyshire and instead use those resources to help tackle the regions suicide fatalities in an alternative, more beneficial manner.

2. Information and Analysis

This local audit has been compiled on a yearly basis since 2008 by the Suicide Audit Group to supplement work by the Suicide Prevention Strategy Group. It was originally set up to comply with national guidance from the Department of Health document: National Suicide Prevention Strategy for England, 2002 which outlined the need to "support research, data collection and monitoring" as one of its six key goals.

The completion of an annual audit is at the discretion of each area, to assess whether or not it is a beneficial exercise for them. The motivation behind the audits is to identify local trends in suicide rates and enable targeting of interventions, for example access to suicide 'hot spots'. In addition, the audits provide cyclical up-to-date figures on how effective these interventions are at reducing deaths. At present, completion of the audit shows Derbyshire's eagerness to comply with the national recommendations alongside its Suicide Prevention Strategy.

However, as part of the evaluation of public health resources, the audits have been analysed. As well as reporting on suicide figures, the audits made yearly recommendations on how the collection, reporting and

analysis of deaths could be improved. Within this, there were recurring themes over several years (see Appendix 1). Advice has been sought from members of the audit group and the Mental Health Joint Commissioning Board who were involved in implementation of recommendations. From this analysis it can be seen that five out of the twenty were either vague or not of a measureable outcome, and therefore cannot be commented on. It is suggested for these reasons that although the audit has been useful in making aims and intentions for progression, it has reached the limit of its productivity due to its lack of specificity, primarily due to the reasons mentioned below.

Evidence of the effectiveness and limitations of local suicide audit has been sought from the literature which indicates that the process has significant limitations that affect the quality of the data collected and mean that more could be gained from an alternative approach. The data reported in the audit is subject to significant time delay and confidentially issues. This affects the accuracy of the already small numbers involved and makes useful statistical analysis difficult. Potentially useful information e.g. ethnicity is lacking from the audits and there is no system in place to collect this.

The careful individual analysis of each suicide death will not be lost by the termination of the suicide audit. These are conducted within Mental Health Trusts, where appropriate, so that individual case by case lessons can be learnt by the health professionals in direct contact with the at risk population. In addition, it is proposed that the annual Derbyshire suicide death figures continue to be reported in the Joint Strategic Needs Assessment as this will ensure that this important aspect of public health remains at the forefront of our priorities.

3. Other Considerations

In preparing this report the relevance of the following factors has been considered: legal, financial, equality and diversity, health, environment, transport, property and crime and disorder considerations.

4. Background Papers

- Derbyshire County and Derby City Primary Care Trusts. Audit of Suicides and Open Verdicts. NHS Derbyshire City & County. 2008-2011.
- Department of Health. National Suicide Prevention Strategy for England. London : Department of Health, 2002.
- Government, HM. Preventing suicide in England: A cross-government outcomes strategy to save lives. Department Of Health, 2012.
- Department of Health. Saving Lives: Our Healthier Nation. 05 July 1999.

- All Party Parliamentary Group. The Future of Local Suicide Prevention Plans in England. Madeleine Moon MP.January 2013.

5. Key Decision

No

6. Is it necessary to waive the call-in period?

No

7. OFFICER'S RECOMMENDATION

That Cabinet approves the proposal to cease the production of an annual Derbyshire suicide report and instead make the figures as part of the annual Joint Strategic Needs Assessment.

Elaine Michel
Director of Public Health

Appendix 1

Recommendation	2008	2009	2010	2011	Achieved in 2012
PCT to deliver education workshops to primary care staff	y		y	y	SAPT funded y
Lessons from suicide reviews should be reported every 6 months to the Strategic Suicide Prevention Group by the PCTs' Patient Safety Team	y	y	y	y	
The partnership between audit group and PCT to raise awareness and training to internal communication officers and journalists to be completed in the next year		y	y		Y
Primary care governance leads to consider how to improve number of practices doing suicide reviews	y			y	
The suicide audit to inform the PCTs' suicide prevention action plans	y	y		y	y
PCT's Promoting Mental Health in the Workplace strategy and booklets to be promoted and shared	y			y	Y voluntary sector with SAPT
The Strategic Suicide Prevention Group should consider the finding from the recent publication on mental health disorders, suicide and deliberate self-harm in Lesbian, gay and bisexual people	y	y		y	y
Clinical governance team to support practices to implement action points & learning needs	y			y	Y County only
Clinical governance and commissioning teams to address mental health care significant reviews in a timely manner	y			y	
Mental health commissioners to consider access issues to counselling and crisis support	y			y	y
Primary Care Clinical Governance team to engage general practitioners' in the notification of suicides to the PCT and the conduct of significant audit reviews	y				Y county only
Focus on high risk groups & improving community resilience					y
The new suicide prevention strategy should be implemented			y		Y built into local strategy
Suicide prevention group to consider implications of national economics in terms of funding delivery of suicide prevention strategy and overall impact of recession on the wellbeing of the local population.			y		y

Further consideration should be given regarding the collection of ethnicity data in Derby City PCT		y			
DMHT, the PCTs and general practice to identify any areas of joint learning with regard to the commissioning and development of local mental health services with particular reference to the recent Rule 43 Coroner letter.		y			y
Lessons from Mental Health Trust suicide audit to be shared with the PCT				y	
All suicide deaths to have serious untoward incident review					y
Consistent use of GP serious incident toolkit					y
The Strategic Suicide Prevention Group and Patient Safety Team are asked to consider the future format of local suicide audits in the light of the recent peer reviewed publication on the value of this process.				y	Y