Public Board of Directors
Item number: 14
Date: 24 September 2025

Confidential/public paper:	Public
Report Title:	**Annual Report – Suicide Prevention England 2025**
Author(s)	Darren McCarthy – clinical risk and patient safety advisor
Accountable Director:	Dr Helen Crimlisk – executive medical director
Presented by:	Dr Helen Crimlisk – executive medical director
Vision and values:	The Trust vision is to improve the **mental, physical and social wellbeing of the people in our communities.** Suicide Prevention ensures that **we keep improving**, whilst **we work together** so **we are inclusive.**
Purpose:	This report outlines the key findings from the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) Annual Report for 2025 and the new Suicide Prevention Strategy for England: 2023 to 2028.
Executive summary:	1. This report outlines the key findings from the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) Annual Report for 2025 and the new Suicide Prevention Strategy for England: 2023 to 2028. 2. The report outlines the work being undertaken in SHSC to ensure a continued focus on suicide prevention to reduce the risk of suicide in SHSC service users. It reports how this will be shared and incorporated into the SHSC Suicide Awareness Training offer. 3. This report is to update on the new national guidance - Staying Safe from Suicide - Best Practice Guidance for Safety assessment. This report will discuss the key principles of the guidance, how it impacts on our current delivery service and what is required from the guidance. It discusses the existing and ongoing work within SHSC, in terms of our current position with the guidance, and projects that are ongoing. 4. The report outlines the work being undertaken with the Director of Public Health and partners to support the development of an updated City-wide Suicide Strategy.

Which strategic objective does the item primarily contribute to:					
Effective Use of Resources	***Yes***	**x**	***No***		
Deliver Outstanding Care	***Yes***	**x**	***No***		
Great Place to Work	***Yes***	**x**	***No***		
Reducing Inequalities	***Yes***	**x**	***No***		

What is the contribution to the delivery of standards, legal obligations and/or wider system and partnership working.	
• New national guidance is to be implemented across all mental health providers in England. • This guidance supports the government's work to reduce suicide and improve mental health services. • NCISH data used to continue to ensure that SHSC are using evidence-based practice to influence training and service delivery.	
BAF and corporate risk/s:	**BAF 0024** There is a risk that the organisation fails to meet fundamental standards of care, legal, regulatory, and safety requirements.
Any background papers/ items previously considered:	Annual Report – Suicide Prevention England 2024 Staying Safe from Suicide – Best Practice Guidance 2025 Executive Management Team 4 September 2025 Quality Assurance Committee 10 September 2025
Recommendation:	The Board of Directors are asked to: • Note the content of the report for **assurance** and compliance purposes. • **Approve** the report. • **Comment** on the report where required.

Board of Directors

24 September 2025

Suicide Prevention in England

1. Purpose of the report

This report outlines the key findings from the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) Annual Report for 2025 and the new Suicide Prevention Strategy for England: 2023 to 2028.

The report outlines the work being undertaken in SHSC to ensure a continued focus on suicide prevention to reduce the risk of suicide in SHSC service users. It reports how this will be shared and incorporated into the SHSC Suicide Awareness Training offer.

The report outlines the work being undertaken with the Director of Public Health and partners to support the development of an updated City-wide Suicide Strategy.

This report is to update on the new national guidance - Staying Safe from Suicide - Best Practice Guidance for Safety assessment.

2. Background

Death by suicide is a tragedy for individuals, families and communities, and its prevention is a public health and clinical priority. Although most people who die by suicide are not known to mental health services, the presence of mental health problems (particularly mood disorders) is a significant risk factor for death by suicide. People with mental health problems who are receiving specialist mental health care are disproportionally more likely to die by suicide. Every death by suicide is a tragedy for the person involved and also for the family and community who are impacted by it.

The annual report of the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) was published 2025. The new 5-year National Suicide Prevention Strategy (Suicide prevention strategy for England: 2023 to 2028) was published in September 2023. The publication influences the national and local strategies.

In April 2025 the new national guidance, Staying Safe from Suicide - Best Practice Guidance for Safety was published. This was a piece of work completed collaboratively across different organisations in England for NHS England. The guidance aims to change the narrative of suicide assessment and prevention work. Predominantly this focusses on the risk assessment tools and methods that have been in use across mental health services.

Suicide prevention also requires wider cooperation and coordination than that at the level of an individual organisation. SHSC is a key part of the broader Sheffield and South Yorkshire programmes on suicide prevention and is contributing to the development of a new City-wide Suicide Prevention Strategy with partners from across the city.

The current paper applies the national findings from NCISH to the work that SHSC is undertaking in areas that have the potential to impact on suicide prevention in service users of SHSC, via the implementation of the Clinical and Social Care Strategy, Therapeutic Environments Programme and developments in SHSC's Suicide Awareness Training.

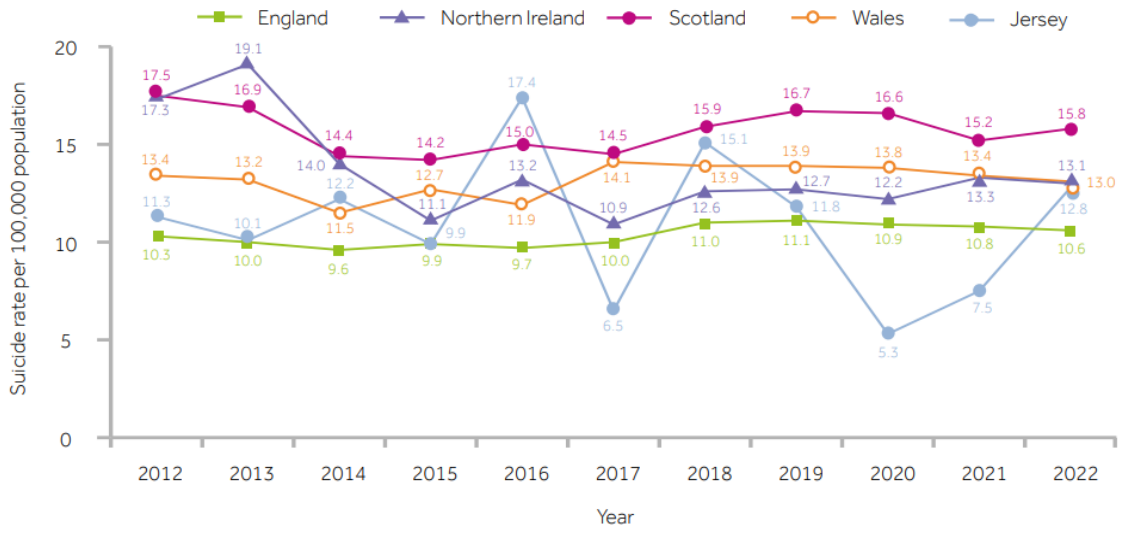
3. Suicide in the UK General Population 2012 - 2022

Between 2012 and 2022, NCISH was notified of 70,590 deaths in the general population in the UK and Jersey that were registered as suicide or "undetermined", an average of 6,417 deaths per year.

In England and Wales there were higher rates of suicide deaths occurring in 2017 and 2018 following the lowering of the standard of proof used by coroners that was introduced in 2018, and then a plateau. However, figures in 2022 are expected to rise once late inquests are added.

In Scotland there were higher rates from 2018 compared to those in 2014-2017. Northern Ireland rates were lower from 2015 which reflect a change in how some deaths are classified (see details of the Review of Suicide Statistics in Northern Ireland). In Jersey the rates fluctuated, being based on small numbers

Fig. 2: General population suicide rates in the UK and Jersey



4. Suicide in Mental Health Patients in the UK 2022

Over 2012-2022, there were 18,670 suicides by patients in the UK and Jersey, an average of 1,697 deaths per year, 26% of all general population suicides.

Fig. 4: Number of mental health patients who died by suicide, by sex in the UK and Jersey

The number of patient suicides increased in 2018 following a change in the standard of proof for suicide at inquest. In England and Wales, an increase in suicides registered in 2023, suggesting a possible rise in suicides occurring in 2022, has been reported by the Office for National Statistics. It is too early to say if this rise will be evident in our 2022 patient suicide figures.

A high proportion of patients who died by suicide showed evidence of isolation and social adversity; nearly half (47%) lived alone, and a sixth (17%) had recently experienced serious financial problems . Suicide related internet use was reported in 8% of patients.

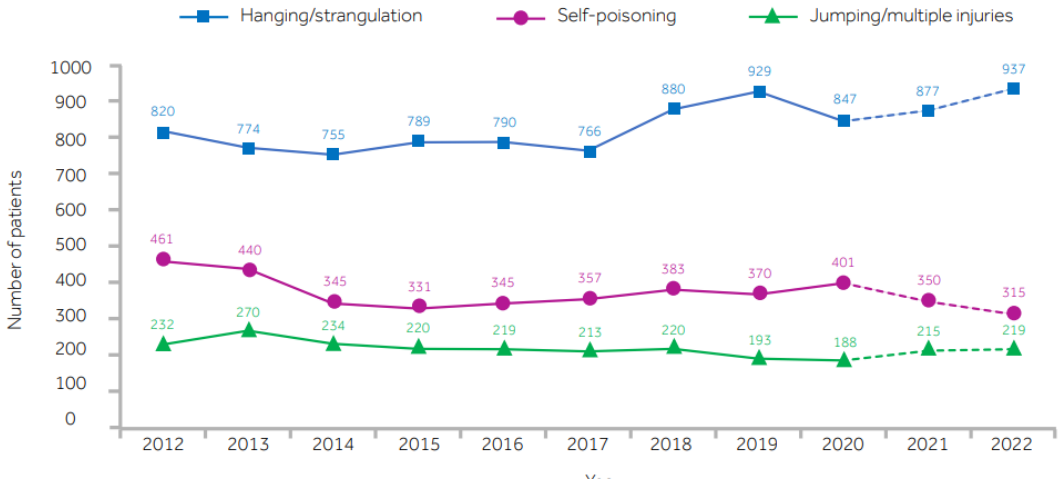
A history of alcohol (47%) or drug (38%) misuse was common. Over half (55%) had a comorbid (i.e. additional) mental health diagnosis. The majority (62%) of patients who died had a history of self-harm. The proportion who had recently (<3 months) self-harmed (31%) has increased over the report period.

The most common methods of suicide were hanging/strangulation (9,164, 49%), self-poisoning (4,098, 22%), and jumping/multiple injuries (2,423, 13%). Hanging/strangulation increased by 14% during 2012-2022, especially after 2017 when the standard of proof for suicide was lowered (Fig. 6).

The increase was especially seen in women, from an average of 39% of all female deaths in 2012- 2015 to 46% in 2019-2022. The number of deaths by jumping/multiple injuries has fallen by 30% in 2013-2020 but we are estimating an increase in 2021-2022. The number of self-poisoning deaths fell in 2014 but has risen by 21% between 2015 and 2020, though we are estimating a fall in 2021-2022 (Fig. 6).

Overall, opiates (including opioid compounds) were the most common substances used, accounting for a third (1,123, 33%) of deaths by self-poisoning, though the number of deaths using opiates or opioids fell by 44% between 2012 and 2021

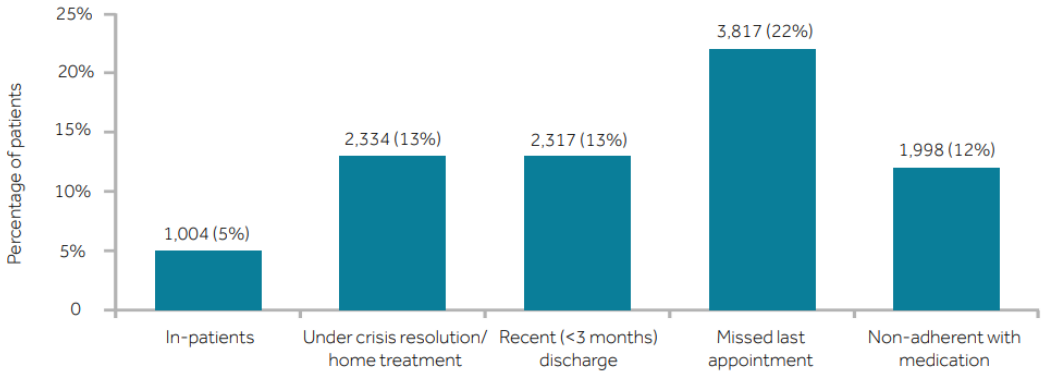
Fig. 6: Main suicide methods by mental health patients in the UK and Jersey



5. Suicide in Acute Mental Health Care Settings 2012 - 2022

During 2012-2022, there were 4,718 patients (27%) who died by suicide in acute care settings (in-patients, under crisis resolution/home treatment, recently discharged from in-patient care), an average of 429 deaths per year (Fig. 10). The proportion under acute care has fallen in 2019-2022 (25%) compared to 2012-2015 (30%).

Fig. 10: Service characteristics of mental health patients who died by suicide (UK and Jersey, 2012-2022)



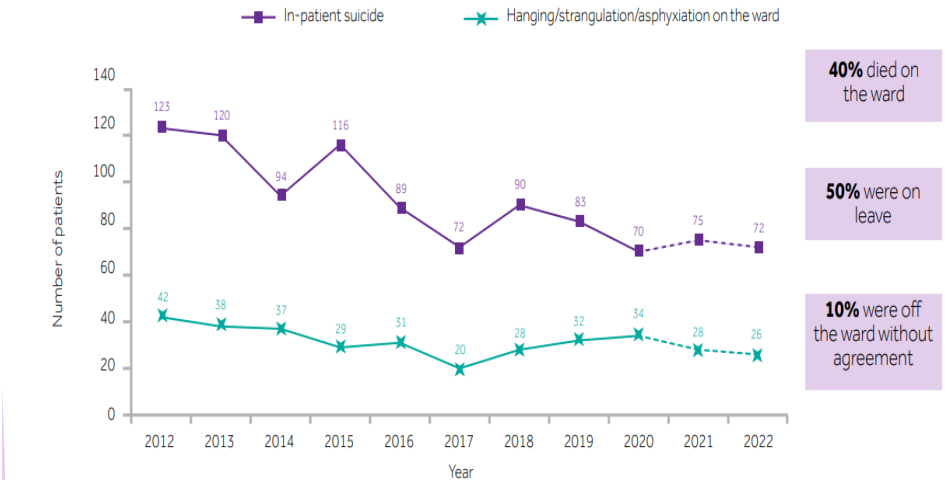
There were 1,004 in-patient deaths by suicide in 2012-2022, representing 5% of patient suicides overall during this time period. This percentage has decreased since 2016, dropping to 4% in 2022. 22 (2%) were aged under 18 and 92 (10%) were aged 18-24.

There was a 41% fall in the number of in-patients who died by suicide between 2012 and 2022, although figures in 2020- 2022 have not fallen (Fig. 11). We also found rates of in-patient suicide per 10,000 admissions fell by 33% in 2012-2022, i.e. taking into account the total number of in-patient admissions in the UK.

Over a third (353, 40%) died on the ward; half (432, 50%) had left the ward with staff agreement; and 87 (10%) had left the ward without staff agreement or left with agreement but failed to return. There was a 31% increase in the proportion of in-patients who died on the ward in 2019-2022 compared to in 2012-2015 (47% v. 36%).

The increase was seen in those aged under 25 (20, 61% v. 17, 39%). The majority (316, 90%) were by hanging/ strangulation/asphyxia; the number of these deaths fell in 2012-2017 but have since remained stable and account for an average of 30 deaths per year (Fig. 11). Overall, a third (301, 34%) had been detained under Mental Health Act powers, half (152, 51%) of whom died on the ward compared to a third (198, 33%) of voluntary in-patients.

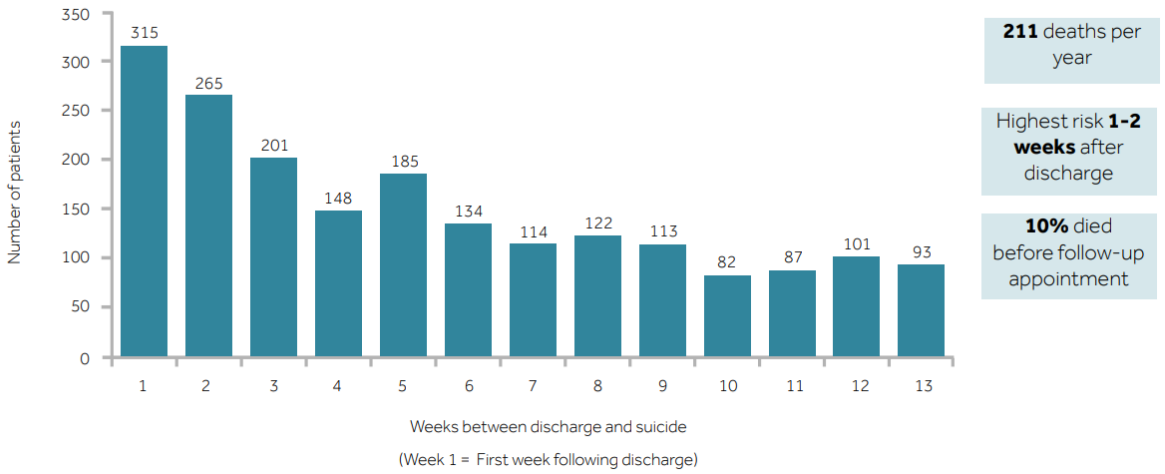
Fig. 11: Number of mental health in-patients who died by suicide and number who died by hanging/strangulation/asphyxiation on the ward in the UK and Jersey



There were 2,317 patients who died by suicide within 3 months of discharge from in-patient care, 13% of all patient suicide deaths, an average of 211 deaths per year. 13 (1%) were aged under 18 and 165 (8%) were aged 18-24.

The number and rate of suicides by patients within 3 months of discharge fell in 2013-2017 but have since risen. In the UK, the average rate of suicide over the report period was 14.1 per 10,000 discharges

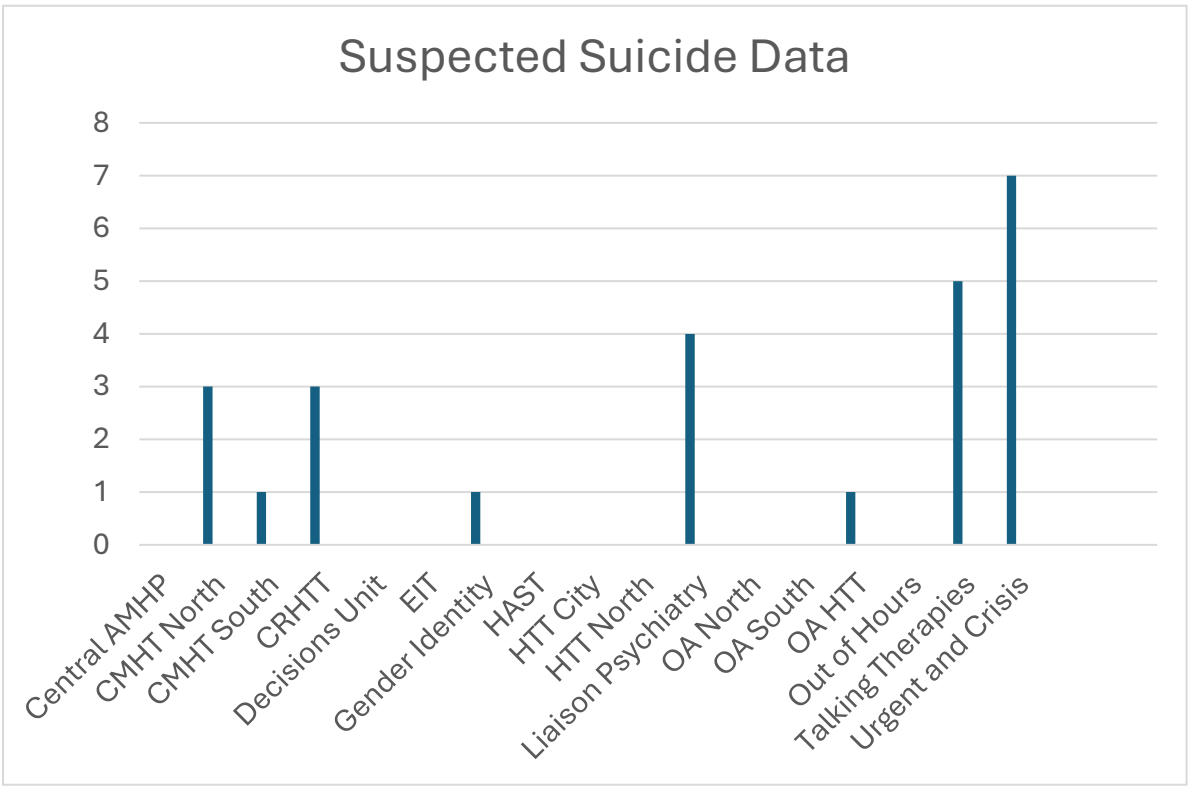
Fig. 13: Number of mental health patient deaths by suicide per week following discharge (UK and Jersey, 2012-2022)



6. Suicide in SHSC by Service Settings Review August 2024 to August 2025

During the period August 2024 to August 2025 there were 25 suspected suicides in SHSC. Of the 25 deaths zero were reported in inpatient settings.

The 25 deaths in the community were from a variety of different settings, as detailed below:



There were no areas identified that had anomalous numbers of suspected suicides, however as expected areas dealing with those in crisis or new referrals to the services saw a higher number of suspected suicides (Psychiatric Liaison).

7. Learning Outcomes from Serious Investigations

Since November 2023 SHSC has adopted the new Patient Safety Incident Response Framework (PSIRF), replacing the previous Serious Investigation Framework (SIF). However, data has been used for the purposes of learning from the previous investigations undertaken under the SIF process (as no investigations have yet been completed under PSIRF currently).

Much of the learning into suspected suicides/unexpected deaths had no real bearing on the incident itself, nor did it present any direct learning around suicide prevention that was not already known through the NCISH/national data.

Much of the learning from the investigations did not fit into the 'contributary factors' or 'missed opportunities' sections of the investigation, with the majority forming the 'lessons learnt' section. Much of the lessons learnt related to information around service procedures, showing that recommendations reflect system issues, as opposed to patient safety issues. Below are some examples taken from SHSC investigation recommendations:

- Ensure there are processes in place for Junior Doctors/on-call doctors working in areas they have not previously worked or in competencies that are required i.e. full crisis assessments
- Liaison Psychiatry to ensure there is a clear escalation process for staff new to the team for support and quality assurance of assessments
- Review joint working process/communication between Primary Care Mental Health Team and SHSC
- That the contents of this report be shared with the South Recovery Team for learning, and all Community Mental Health Teams to be reminded of the safeguarding adults policy
- Review the options for people in crisis out of hours, where A&E attendance is not considered to be suitable.

The above information aligns with the move away from investigating all suicides in line with the new PSIRF guidance, as it has been shown that the learning from investigation suicide is extremely limited. This has led SHSC to develop and provide 'Human Factors and Systems Thinking' training starting in 2022 and the subsequent 'PSIRF Human Factors and Systems Thinking Update' training which was launched in 2024.

Learning from incidents is now completed locally within the teams in After Action Reviews and Learning Responses, allowing quicker learning from incidents that is within the teams the incident occurs. This allows for patient safety incidents to be quickly responded to, sharing learning with the areas where the incidents occurred.

However thematic reviews and Structured Judgement Reviews are also used to look at the wider patient safety issues that may present as a system issue. In these reviews information from a variety of sources is analysed to identify system issues, and then make actions and recommendations on how to improve the systems. System by their very nature are designed to support patient safety, however these systems are prone to atypical/unexpected failures, circumvention with humans, or changes to ways of working where the systems have not been adapted to the changes. By using this sort of learning we can develop changes to the system to support our services users and staff safety.

Many of the recommendations or actions that have come from learning/coronial processes aligns with the system thinking approaches discussed above. A recent Prevention of Future Death Notice highlighted record keeping and communication as an area for improvement directly linked to patient safety and suicide prevention. The recommendations from this have been incorporated into both the Suicide Awareness training and the Record Keeping Standards training.

8. **Autism and ADHD**

350 autistic people died by suicide, which equates to 2% of all patient suicides and an average of 32 deaths per year. There were 159 people with ADHD who died by suicide, 1% of all patient suicides and an average of 15 deaths per year. The number of autistic people and those with ADHD increased over this ten-year period, are likely a reflection of an increase in clinical recognition and diagnoses of these disorders over this period.

In SHSC there are workstreams and processes in place which aim to reduce suicides in this specific demographic, and include green light working, autism specialist trained staff, and a model for new female ward being planned with ASD specialisms in mind and specific skill mix model to support this.

9. **Young People (Under 25)**

There has been recent concern over in-patient safety for young people. There were 117 deaths by suicide in in-patients who were aged under 25 (10-24 years) in 2011-21, an average of 11 deaths per year; 20 were aged under 18. In-patients under 25 who died showed high rates of clinical risk factors associated with suicide, including self-harm, alcohol and/or drug misuse, and childhood abuse. Half had been detained under Mental Health Act powers. They were more often under enhanced nursing observation. In 43% the admission was at a non-local unit.

There were 869 deaths by suicide by those identified as students, an average of 79 per year. 96 were “mental health patients”. This is a significantly lower proportion than other young people in the general population who died by suicide.

10. **Suicides following one-off assessment.**

There were 1001 deaths by people who had a one-off assessment with mental health services. They were more likely to have had a recent history of drug and alcohol misuse and recent adverse life events such as financial problems or relationship break up.

In SHSC the new Personalised Assessment of Risk work is ongoing to replace the DRAM assessment. The document is based on the 5P’s formulation approach and has been designed in collaboration with NCISH, Culture of Care and other NHS Trusts supporting Culture of Care with the projects. While this is discussed extensively in the latter stages of this document, it is important at this point to discuss that new training for assessments will be available in the coming months for all staff completing risk assessments and the data in this report is being used to inform the training requirements.

There is also increased partnership work occurring with the substance misuse provider and SHSC, with a Liaison Group being set up to promote co-working, and a new shared policy being created to provide guidance for working with people with comorbid conditions.

There has also been an Addiction Tutor appointed via Post Graduate Medicine to develop and maintain skills in substance misuse in Resident Doctors, which was required following external tender, offering additional case discussion opportunities.

11. Suicides in public places

3894 patient suicides occurred in a public place an average of 354 per year. The most frequent places were pars, woodlands and railway networks with an increase in death by hanging or strangulation. Patients who died in a public place were more likely to have psychotic disorders, self-harm, drug use and life stressors.

12. Characteristics of UK Mental Health patients who died by suicide in NCISH (2016 – 2021)

Demographically, mental health patients who died by suicide were more likely to be male (66%) living alone (48%), unmarried (73%) and unemployed (48%). 7% were from an ethnic minority group. 5% identified as LGBT and 1% as trans or non-binary. 2% of patients were pregnancy or within a year of childbirth. Economic adversity was a risk factor for suicide, including loss of job, benefits and home. The majority (71%) had experienced recent adverse life events, particularly financial problems and relationship break up/divorce.

Clinically and behaviourally, of patients who died by suicide 63% had previously self-harmed, 47% had misused alcohol and 38% had misused drugs. They were most likely to have a diagnosis of a mood disorder or a psychotic condition such as schizophrenia, although people diagnosed with “personality disorder” were also at significant risk (11% of deaths). Individuals with “personality disorder” were more likely to have reported past trauma, including abuse, in their lives.

Amongst those from the LGBT+ community who died by suicide, there was an association with previous trauma and abuse.

13. Suicide trends in the South Yorkshire and Sheffield General Population 2010-2020

Yorkshire and the Humber, as a region, has had a consistently higher rate of suicide by comparison with the England average.

Sheffield has generally been below the average England suicide rate, although in 2018-2020 the local rate increased so that the Sheffield rate was higher. In context Sheffield had a lower suicide rate than Yorkshire and the Humber in 9/10 years in the decade 2010-2020, including in 2018-2020.

We do not currently have data in SHSC that is adjusted for population in a way to allow direct comparison with other local, regional and national data. This is an area for further development in our approach to suicide prevention. However, using the national NCISH data at SHSC we are aware that within the City of Sheffield the data nationally correlates to our local demographic data.

However, we do review the deaths of all service users who died by suicide or suspected suicide through the mortality review process and, where appropriate, through the Patient Safety Incident Reporting Framework (PSIRF) process. These processes report through to Quality Assurance Committee and Board of Directors.

We have been provided by NCISH with an SHSC rate of death by suicide of 8.65 per 10,000 people receiving mental health care for the period 2017-2019. This places SHSC in the group of NHS Mental Health Trusts with higher rates for that period. In the context of Yorkshire and the Humber, this region has had a consistently higher rate by comparison with the England average. Sheffield had a lower suicide rate than Yorkshire and the Humber in 9/10 years in the decade 2010-2020, including in 2017-2020.

Yorkshire and the Humber is a large rural area, which is known to be a factor in increased suicidality through factors such as isolation, access to means (higher proportion of farming

and veterinary professionals), however this does account for City wide increases during this time. Sheffield also has an increased population of students, which may have an impact on data. However at this time a full breakdown is not available to access these specific impacts.

14. Relevant Learning from NCISH relating to SHSC Strategy and Transformation

Therapeutic Environments Programme
In relation to inpatient care, the importance of safer and more therapeutic environments is clearly emphasised by NCISH. This closely correlates with the work that SHSC is undertaking to modernise its estate, including the removal of ligature anchor points which has now been completed in the acute adult wards, meeting the requirements of CQC Section 29A.

The ward refurbishments have improved inpatient environments and provided de-escalation facilities to reduce the level of restrictive practice and seclusion as well as improving privacy and dignity.

The refurbishment of Maple Ward remains the final acute area refurb. Further plans to refurb forensic areas, older people and rehab services is planned, but as yet no capitol plan is in place.

Clinical and Social Care Strategy
The NCISH identifies recognition of the importance of trauma as a key factor in reducing suicide. The SHSC Clinical and Social Care Strategy identifies suicide prevention as a central high-level objective. The fundamental principles of the Strategy are highly relevant to suicide prevention: Person-Centred and Trauma-Informed, Strengths-Based and Evidence-Led. Examples of this a self-harm suicide intervention workbook is being trialled on inpatient wards, a research programme is underway with liaison staff delivering harm reduction programmes and compassion focussed therapy for people who self-harm. The ROOTs and trauma informed training and emotional needs pathway have been taken forward across a number of services.

Clinical Observations and Leave policies
In relation to the NCISH observation that periods of leave from wards and discharges are high risk periods. SHSC has recently updated its Section 17 leave policy, including requirements around risk assessment and online training has been developed. Follow up within 72 hours of discharge is part of the acute care pathway, linked with the finding in NCISH that the immediate post-discharge period is a time of higher risk.

Primary Care and Community Care Transformation
The Primary and Community Transformation will enable more people who do not meet the criteria for secondary care. For example, it can be evidenced in Primary and Community Mental Health transformation by the work that is undertaken by teams to support traumatised people, including people who self-harm.

Sheffield Talking Treatments have developed an ethnically diverse outreach team to improve engagement and access to talking therapies in associate with VCSE and Faith leaders.

Talking Therapies have also incorporated including questions around gambling within their assessments, and signpost to gambling support agencies.

Gleadless and Healey projects are currently in development, and as part of this approach services users can been seen more quickly in their local area, amongst other

planned pilot projects in this area. This will also include improved access to debt relief and housing support in this area.

Home First
The Home First project involves working with Flow Coordinators and the CMHT's/HTT/Inpatient areas to ensure that care is happening at the right level for service users, in line with the local and national suicide prevention strategies.

Learning Disability Transformation
The Sheffield Learning Disabilities Transformation will provide support to service users and families over an extended period, with particular focus on psychosocial interventions and the avoidance on inappropriate use of psychotropic medication (STOMP) to provide greater responsiveness, personalisation, a value-based approach (Moulster and Griffiths nursing model) and increased use of positive behavioural support and enhanced Green Light working in mainstream services.

Inequalities
The use of an inequalities flag will improve recognition for people with inequalities and there is an active campaign being monitored to improve recording of protected characteristics. The focus on the importance of recognition of people with protected characteristics such as LGBTQ+ will enable factors affecting this community specifically to be identified and work with the LGBTQ Staff Network has enabled all staff members to become more familiar with asking about sexuality and sexual orientation. Inequalities and the need to adopt a data driven population health approach is a key feature of the Clinical and Social Care Strategy.

15. Sources of Information: Suicide prevention strategy for England: 2023 to 2028
Considerable progress has been made since the last Suicide prevention strategy for England was published in 2012. All areas of the country now have local suicide prevention plans and suicide bereavement services, supported by a £57 million investment through the NHS Long Term Plan.

Evidence shows one of the lowest ever suicide rates (in 2017) and collective efforts to improve patient safety led to a 35% fall in suicides in mental health inpatient settings in England between 2010 and 2020. However, while overall the current suicide rate is not significantly higher than in 2012, the rate is not falling.

16. Overview of Strategy
The strategy calls for collective effort across national government, the NHS, local government, the voluntary, community and social enterprise (VCSE) sectors, employers and individuals.

The overall ambitions set by this strategy are to:

- Reduce the suicide rate over the next 5 years – with initial reductions observed within half this time or sooner
- Improve support for people who have self-harmed
- Improve support for people bereaved by suicide
- Suicide prevention requires partnership working. The NCISH report highlights the risks of economic adversity, including loss of income and home. Although these are not directly within the influence of healthcare services, especially during an economic downturn, we can influence by working in partnership across Sheffield and South Yorkshire with colleagues in local authorities and VCSE. A specific example is reducing the risk of suicide associated with alcohol and substance misuse, which requires a range of measures from individual treatment through to education and public health interventions,

e.g. licensing.

17. Priorities for Action Over the Next 5 years

Data, evidence and engagement with experts (including those with personal experience) has identified the following priority areas for action to achieve these aims. These are to:

- Improve data and evidence to ensure that effective, evidence-informed and timely interventions continue to be adapted
- Provide tailored, targeted support to priority groups, including those at higher risk. At a national level, this includes:
  - Children and young people
  - Middle-aged men
  - People who have self-harmed
  - People in contact with mental health services
  - People in contact with the justice system
  - Autistic people
  - Pregnant women and new mothers
- Address common risk factors linked to suicide at a population level by providing early intervention and tailored support. These are:
  - Physical illness
  - Financial difficulty and economic adversity
  - Gambling
  - Alcohol and drug misuse
  - Social isolation and loneliness
  - Domestic abuse
  - Neurodevelopmental disorders
- Promote online safety and responsible media content to reduce harms, improve support and signposting, and provide helpful messages about suicide and self-harm
- Provide effective crisis support across sectors for those who reach crisis point
- Reduce access to means and methods of suicide where this is appropriate and necessary as an intervention to prevent suicides
- Provide effective bereavement support to those affected by suicide
- Make suicide everybody's business so that we can maximise our collective impact and support to prevent suicides
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18. Key Quotes from the Strategy:

"It is a way of updating our priorities, reflecting new evidence on who is at risk. The new strategy therefore highlights domestic violence, gambling, online safety and people on the margins of society because of poverty, ethnicity, disability or prejudice".

"The aim of this cross-government strategy is to bring everybody together around common priorities"

"Everyone should feel they have the confidence and skills to play their part in preventing suicides – not just those who work in mental health and/or suicide prevention directly – and take action to prevent suicides within and outside of health settings"

19. **SHSC Suicide Prevention Work**

SHSC suicide prevention strategy is guided by the national strategy; however the Sheffield strategy is set out regionally by the Sheffield City Council Suicide leads, with incorporated input from the South Yorkshire Integrated Care Boards (SY-ICB). It is the local strategy which influences SHSC strategy and development of training.

Suicide Awareness Training

The Suicide Awareness Training delivered within SHSC covers the areas within the national and local strategies from the 2012 strategy. However, it has incorporated information from a variety of sources over the period between conception and current training.

While the training is influenced by the strategy, data from the NCISH Annual Reports has been incorporated when released to reflect the ongoing updates, changes and new evidence presented. This allows the training to remain up to date and relevant, providing SHSC staff with the best available knowledge and evidence.

The training package is due for a review in 2025, in line with the new strategy and newly released NCISH data. However the strategy has not identified any areas that were either not been addressed in the current training or suicide risk issues that SHSC were not already aware of, meaning the training will only require minor updates to ensure it fulfils the objectives of the strategy.

Compliance within the Suicide Awareness Strategy was previously highlighted as a cause for concern by the CQC, however over the period of 2022 to 2023 intensive training schedules were implemented to ensure training targets could be achieved, with compliance moving from 18% in 2021/2022 to over 80% compliance from May/June 2023. This level of compliance is continuing to be maintained through regularly scheduled training dates.

Record Keeping Standards

The recent launch of the Record Keeping Standards training continues to strive for improvements in patient safety. The training incorporates elements of care planning, risk assessment, risk formulation, mitigation and safety planning. The training discusses consent and how we share information as an organisation, listening to families to improve safety, and to capture key information when thinking about demographics, risk, ethnicity and vulnerabilities.

20. Highlights for SHSC – How are we going to apply this within SHSC.

Many of the elements of the updated strategy reflect ongoing strategy from the 2012 work. Physical illness, middle aged men for instance are consistent well known risk factors that are already incorporated within SHSC strategy and training.

However, where the new strategy builds on the previous 2012 strategy there are some new key elements included which have a direct influence within SHSC, specifically:

- Autism
- Pregnant women and new mothers
- Gambling

21. Autistic People

Autistic people make up approximately 1% of the population but 11% of suicides, meaning autistic adults with no learning disability are 9 times more likely to die by suicide than the general population (RCPSYCH: Suicide and Autism, a National Crisis).

The NCISH study data reveals that 350 autistic people died by suicide between 2011 – 2021. This figure looked at the year-on-year data, and saw an increase from 13 suicides in 2011, increasing year on year to 61 in 2021. However, the evidence suggests that this is not an increase that has been seen due to other factors increasing suicide risk, moreso that the diagnosis and recognition of autism has increased during this time, reflecting more accurate reporting.

It is this message that has been key for SHSC in its planned response to address the new strategy, in that awareness and appropriate treatment of those with autism is key to the

suicide prevention work we do. As well as the recently launched Oliver McGowan training within SHSC, specific elements of risks for autistic people will be incorporated within the Suicide Awareness Training, highlighting that autistic people are in a high-risk demographic.

Guidance from sources such as the Royal College of Psychiatrists suicide prevention workshops will also be utilised to discuss skills and strategies used in risk assessment and engagement with people with autism to provide support that is flexible, personalised and tailored to meet an autistic person's unique needs.

Additionally as part of the response to the new strategy the Zero Suicide Alliance has recently launched an online training package developed with Greater Manchester NHS Trust. The training is specifically focussed on autism and suicide awareness.

The training can be accessed through the online link, and will also be added to Jarvis and advertised for all SHSC staff to complete: (Autism and Suicide Awareness Training :: Zero Suicide Alliance)

The information around the course from Zero Suicide Alliance states that:

The training has been co-produced with people from the autistic community and aims to:

- Share information about autism and suicide risk
- Share real experiences
- Coach you through spotting the signs and supporting an autistic person with four different scenarios (you can choose which ones you want to complete)
- Share resources for further support
  (Zero Suicide Alliance. 2024).

22. Pregnant women and new mothers

In the UK around one in five women experience a perinatal mental health problem during pregnancy or within the early postnatal years, with around 70% of those hiding or underplaying their illness. However, what is probably most shocking is suicide is the leading cause of direct maternal death within a year of giving birth.

There are many known risk factors that have been identified within the NCISH reports, Papyrus data and the Maternal Mental Health Alliance sources. These increased risk characteristics include:

- Existing mental health conditions
- History of suicidal thoughts or suicide attempts
- Substance abuse, including drug and alcohol abuse.
- Domestic violence and abuse.
- Lack of social support.
- Regular sleep disturbances.
- Past trauma

Again, these risk factors and the evidence base will be incorporated with the SHSC Suicide Awareness training.

23. Gambling

Gambling has become recognised as a key driver in suicidal ideation, and this has been termed gambling-related harms. Although the statistical data on gambling and suicide is in its early stages, the emerging evidence shows links between harmful gambling and suicide. NCISH has only recently begun to collect specific data with links in suicides to gambling, however there is enough supporting information for this to have made it into the new suicide prevention strategy.

Within the Suicide Awareness training at SHSC socio-economic factors are discussed within the training, and it is important to note that gambling links in with debt, financial issues and contributes to poor socio-economic outcomes, which can increase hopelessness and entrapment for instance.

For SHSC the information available will be incorporated into the Suicide Awareness training, with further information emerging from data added in when available.

All teams have been informed about the need to ask about gambling and refer on those with gambling issues. Particular attention has been paid to this in Sheffield Talking Therapies and Primary Mental Health Teams where people may present with gambling issues. A research project is due to start soon investigating the recognition of gambling in Primary Mental Health Teams.

24. Staying Safe from Suicide - Best Practice Guidance for Safety 2025

In April 2025 the new national guidance, Staying Safe from Suicide - Best Practice Guidance for Safety was published. This was a piece of work completed collaboratively across different organisations in England for NHS England. The guidance aims to change the narrative of suicide assessment and prevention work. Predominantly this focusses on the risk assessment tools and methods that have been in use across mental health services.

The guidance discusses the need for change, and why, and the new recommendations for what this change looks like. This report aims to discuss the key recommendations from the guidance, and to address the work undertaken within SHSC to provide assurance around how the guidance is reflected in practice, including in training, communications and ongoing projects.

Progress and Ongoing Works

25. Recommendations from the Guidance

There are many recommendations from the guidance, and while this report will not explicitly list them all, relevant points will be listed below.

Who should implement this guidance:

The guidance applies to all mental health practitioners in England, working in both community and inpatient settings, and supporting people of all ages. It is recommended that the guidance should be adopted by public, private and voluntary sector providers, including independent practitioners.

What are the drivers for change?

‘The ‘low-risk paradox’ – that most people in contact with mental health services who die by suicide have been assessed as being at low or no risk of suicide – shows that suicide prediction tools, scales, and stratification (for example, into low, medium, or high risk) don’t work. This has been well established by research

And yet the use of static risk stratification persists. It is supported by myths, including the belief that it minimises liability or standardises care. In some areas, a tick-box culture has developed, using forms and checklists that are unvalidated and have no predictive value.

Both the former Chief Coroner and the Health Services Safety Investigations Body (HSSIB) have raised concerns about risk prediction and stratification, and the National Institute for Health and Care Excellence (NICE) guidance Self-harm: assessment, management and preventing recurrence (NG225) emphasises replacing risk prediction methods with a psychosocial approach.

Instead of stratification, practitioners are recommended to explore risks collaboratively, understand changeable safety factors, and co-produce safety plans. Risk is too variable to rely on static categories—it demands nuanced, relational care. NG225 says:

- **do not** use risk assessment tools and scales to predict future suicide or repetition of self-harm
- **do not** use risk assessment tools and scales to determine who should and should not be offered treatment or who should be discharged
- **do not** use global risk stratification into low, medium, or high risk to predict future suicide or repetition of self-harm
- **do not** use global risk stratification into low, medium, or high risk to determine who should be offered treatment or who should be discharged
- focus the assessment on the person's needs and how to support their immediate and long-term psychological and physical safety.
- mental health professionals should undertake a risk formulation as part of every psychosocial assessment

This guidance builds on NG225's approach and removes any uncertainty about what should be done. Practitioners and organisations should eliminate unvalidated and unacceptable practices that have become embedded in the system and replace them with the approaches set out here.

It supports the National Suicide Prevention Strategy (2023), which committed to improving mental health services, and aligns with the Culture of care standards for mental health inpatient services (2024).'

Recommended Approach:

All mental health care and treatment should be undertaken using a biopsychosocial approach, seeing individuals as having complex physical, emotional and social needs and strengths within a wider relational approach. Attention to safety should be part of the wider approach to mental health care.

Key Principles:

The 10 key principles of the approach are:

1. **relational safety:** build and maintain trusting, collaborative therapeutic relationships. These are the strongest predictor of good clinical outcomes
2. **biopsychosocial approach:** address safety as part of a broad biopsychosocial approach aimed at improving overall well-being by considering biological, psychological and social aspects
3. **safety assessment and formulation:** reach a shared understanding with the individual about safety and changeable factors that may affect this
4. **safety management and planning:** consider the need for immediate action and work with the individual to navigate safety and the factors impacting this over time.
5. **dynamic understanding:** regularly assess and adapt formulations and safety plans based on the individual's changing needs and circumstances
6. **evidence-based practice**: base work on the latest research and understand population-level risk trends

7. **involving others:** encourage the involvement of trusted others, where possible and as appropriate
8. **inclusivity:** Ensure practices are inclusive and adaptable, particularly for marginalised and high-risk groups
9. **clear communication:** use simple language tailored to the individual and don't use jargon. Use interpreters or approaches like drawing, if needed
10. **continuous improvement:** regularly review and refine approaches based on outcomes and feedback

The guidance discusses its recommendations from moving away from a 'tick box exercise' toward a collaborative discussion around risk, and has the following recommendations for how to achieve this. These include the recommendation around biopsychosocial assessments, building collaborative relationships and gathering of information.

The guidance specifically makes recommendations to safety formulation and what this should look like. The guidance advises using the 3 Ps approach for formulation, but goes on to state that use of the further 2 Ps (to make the 5 Ps) will allow for a broader formulation.

The 5 Ps consist of:

1. **Presenting problem**: What are the current difficulties with staying safe?
2. **Precipitating factors**: What increases risk?
3. **Protective factors**: What reduces risk?
4. **Predisposing factors**: Relevant longstanding or past factors that underlie current problems.
5. **Perpetuating factors:** Current stable factors that maintain problems. For example, addictions.

The guidance continues with safety management and safety planning, and states:

Safety management is a key part of an individual's wider care plan, which should be built collaboratively and focus on their emotional, social, and physical well-being and engage, where appropriate, with the individual's family and trusted others. Safety management is a dynamic process that evolves over time and has two components: immediate safety actions and longer-term safety planning.

Safety plans should help individuals identify warning signs, manage crises, and build support networks. They should be based on the shared understanding developed during the assessment and formulation process and should be written down, reviewed, and shared, as appropriate, with the individual's family, carers or trusted others.

Language

The report talks about the use of language throughout the assessment and states 'language shapes thoughts, feelings, and actions. Changing how we talk about suicide is crucial to reducing stigma and encouraging people in distress to seek help and to talk'. The guidance recommends adopting 'staying safe' language and goes onto detail how this can be used. Language in the wider context will be discussed in the SHSC response section below.

Local Actions

The report summarises its recommendations for local actions for individual areas, listed as such:

- secure senior leadership support, including an executive lead for implementation
- create a detailed implementation strategy with clear timelines
- appoint local champions to drive implementation
- involve service users and stakeholders in the process

- provide training and supervision for all mental health practitioners
- prioritise staff well-being during safety assessments and planning
- align training and education programs with the guidance
- collaborate across disciplines and teams
- update record systems to eliminate risk stratification
- monitor progress (including patient experiences) and evaluate outcomes
- share knowledge, including through the Staying safe from suicide resource hub

26. SHSC's Current Position in Relation to the Guidance – Suicide Strategy

SHSC suicide prevention strategy is guided by the national strategy; however the Sheffield strategy is set out regionally by the Sheffield City Council Suicide leads, with incorporated input from the South Yorkshire Integrated Care Boards (SY-ICB). It is the local strategy which influences SHSC strategy and development of training.

The Suicide Awareness Training delivered within SHSC covers the areas within the national and local strategies, as well as local learning. While the training is influenced by the strategy, data from the NCISH Annual Reports has been incorporated when released to reflect the ongoing updates, changes and new evidence presented. This allows the training to remain up to date and relevant, providing SHSC staff with the best available knowledge and evidence.

Within the suicide awareness training, elements of the new guidance are already covered and require no major changes to the training. These elements are specifically around the use of language, compassionate and collaborative assessment, formulation of risk and risk mitigation, and safety planning work. Staff wellbeing around these assessments is also extensively covered, with the first hour of the training being focussed on self-care and staff wellbeing.

The suicide training offer also makes explicit reference throughout around the low risk paradox, and the NICE Guidance NG225 (low/medium/high). The training also discusses how risk assessment has been shown to not predict or prevent future harm, and discussed strategies to develop safety measures and observe for warning factors and signs.

The suicide awareness training is evidence based, and uses the Integrated Motivational Volitional Model (Professor Rory O'Conner, 2018 - The IMV Model – Suicidal Behaviour Research Laboratory).

27. SHSC's Current Position in Relation to the Guidance – Personalised Assessment of Risk Project

In 2024 SHSC applied to be on the Culture of Care/NCISH Personalised Approach to Risk project. This was an opportunity to be selected as one of the ten Trusts across England to be involved in this project, and we were successful in being selected.

Whilst the level of support has been limited, the project was undertaken at SHSC and has been in development since September 2024. The aim of the project was to look at risk assessment within our organisation and to seek to make improvements. Other Trusts involved in the project have sought to make changes to their training and development, or to adjust some of their ways of working.

However, at SHSC the decision was made that we would seek to completely change the way we complete risk assessments. This includes the design of a completely new risk

assessment tool, new training, new guidance, new policy and a cultural change approach to risk within SHSC.

Since September 2024 the Personalised Assessment of Risk project has been undertaken. In this time SHSC have:

- Formed a working group consisting of appropriate people (digital/Culture of Care/QI/Leadership).
- Formed a Stakeholder group to make collaborative co-produced decisions on the project (consisting of lived experience representation/multidisciplinary representation across SHSC).
- Developed a new risk assessment document
- Developed and delivered training for the pilot project areas (DD2/North and South CMHT).
- Communicated the project across differing levels/areas (EMT/Board/QAC/CQ&SG, but also externally to our partner organisations such as Flourish/Amparo/SACMHA, to Sheffield City Council partners and to the ICB).
- Developing training for all SHSC staff.
- Developing guidance for all SHSC staff.
- Developing the policy to support the new document.
- Rio build for the final approved template.

28. SHSC's Current Position in Relation to the Guidance – Personalised Assessment of Risk Project – Specifics (design).

Through the Stakeholder involvement and support from other organisations, an options appraisal process was followed to have informed choices around the document design.

Three proposals were given as options to the stakeholder group. Responses were captured and a consensus was reached around the initial design of the document. While at this time the new national guidance had not been released, the lead on the project was aware of much of the research evidence which would be guiding the development of the national guidance, and much emphasis was put into the design of the document.

The chosen document uses the 5 Ps approach as its baseline for the assessment. It also has a specific area for family/friend/carer views which aligns with the new guidance. The new document design also incorporates the formulation of risk elements discussed in the guidance, as well as the immediate plans, crisis management and links directly to safety planning. Sharing of the document is encouraged in the same way care plans should be shared, and the document has a section for reviews to ensure they are regularly reviewed.

For the design of the document please see appendix A. While the Rio build is being processed, the design is in template form in a Word document to allow for the pilot project to occur. This occurred due to the move from Insight EPR to Rio EPR and the timings of the project.

29. SHSC's Current Position in Relation to the Guidance – Personalised Assessment of Risk Project – Specifics (guidance).

Individual guidance for the risk assessment has been/is in development. This guidance will allow assessing staff to tailor their assessment approaches to the needs of the individual. For instance if a service user is referred in and has a diagnosis of Autism, then the assessing practitioner will be able to utilise specific guidance on risk related to Autism (increased risk factors for instance).

Generalised guidance remains in place, however having a resource of specific other guidance will allow for a more comprehensive risk assessment.

30. SHSC's Current Position in Relation to the Guidance – Personalised Assessment of Risk Project – Specifics (training).

Training has been developed to reflect the current evidence-based practice. This incorporates the narrative of the guidance in terms of:

- Use of language
- Collaborative formulation
- Risk mitigation
- involvement with family/friends/carers
- Empowerment and ownership of risk by service users
- Prediction not attainable and risk assessments should not be used to try to predict risk
- NG225 guidance
- Psychosocial formulation
- Compassionate coproduction of the assessment
- Lived experience examples by lived experience service user involved in the project from the beginning

The training/guidance will be available via fully dedicated risk assessment homepage on Jarvis – accessible by all 24 hours a day. This will include links to the national guidance throughout.

Local senior staff champions will also be identified and have bespoke training. This will be to ensure they are supporting the staff within their areas, be an expert by example on the risk assessment and formulation, and also be the staff to audit and evaluate the quality of the risk assessments. An audit tool is being developed to support with this process.

31. SHSC's Current Position in Relation to the Guidance – Personalised Assessment of Risk Project – Specifics (coproduction).

The project has involvement of lived experience and a variety of disciplines. The design and development of the project has sought and continues to seek coproduction at every level.

This includes the production of a leaflet for our service users discussing what a risk assessment is and why we conduct one. Feedback has been that service users do not normally know they have a risk assessment, let alone feel it has been collaborative. By having a leaflet the hope is that it will inform and empower our services user to be involved and equally take control and manage their individual risk.

The leaflet design is currently in development, but this also includes artwork design proposals from our lived experience colleagues.

32. SHSC's Current Position in Relation to the Guidance – Personalised Assessment of Risk Project – Specifics (local actions).

The Personalised Assessment of Risk Project has already aligned itself to the national guidance. The project has completed some of the local actions, and is well designed to complete the remaining as listed below:

- secure senior leadership support, including an executive lead for implementation
    - Complete

- create a detailed implementation strategy with clear timelines
    - Complete – QI support has been instrumental with the design of the GANTT chart and monitoring processes
- appoint local champions to drive implementation
    - Ongoing with the development of the training offer
- involve service users and stakeholders in the process
    - Complete and ongoing from the Stakeholder group and our lived experience partners.
- provide training and supervision for all mental health practitioners
    - Ongoing with the development of the training offer
- prioritise staff well-being during safety assessments and planning
    - Ongoing with the development of the training offer, but also incorporated in the Suicide Awareness Training
- align training and education programs with the guidance
    - Ongoing with the development of the training offer
- collaborate across disciplines and teams
    - Ongoing with the development of the training offer, but also the Stakeholder group work incorporates this action.
- update record systems to eliminate risk stratification
    - Complete with changes to the current DRAM in 2022
- monitor progress (including patient experiences) and evaluate outcomes
    - Follow up Stakeholder groups and audit procedures will monitor this action
- share knowledge, including through the Staying safe from suicide resource hub
    - Jarvis homepage to reflect learning, and additionally with our involvement with the pilot project SHSC already have representation of our project and learning on the resource hub

33. Focus on work of Sheffield Talking Therapies

Staff in Sheffield Talking Therapies (STT) are an important group to be aware of the risk of suicide. A bespoke training has been developed for these staff which outlines the national priorities regarding suicide prevention.

The perinatal period is recognised to be particularly important - patients are assessed within 2 weeks and treatment commences within 4 weeks. The DNA policy is flexible for this population and staff routinely offer a further appointment to anyone on this pathway following a DNA due to increased vulnerabilities. There is a perinatal working group in the service that is looking to deliver CPD to enhance skills and knowledge needed to support people on this pathway and suicide risk/prevention will be included within this training.

A new senior PWP will have protected time to work on the pathway in collaboration with Start for Life funded by Start for Life monies to promote a joined-up approach to working with people on this pathway. They will link with perinatal service, Start for Life, to increase knowledge of services to support people holistically. PWPs are also doing clinics in Family Hubs to make the service more accessible to people on this pathway.

STT also has a neurodiversity working group, older adults and BAME working group to improve equality of access and outcomes for all. The equalities team delivers clinics in voluntary and community sector to increase visibility and presence including wider engagement work focussed on Men.

STT has a long-term conditions arm that works across 13 health conditions and the interplay between physical and mental health

STT is part of a national roll out of employment advisors to support people to stay in work and to gain employment. Recruitment is ongoing and will accelerate once funding from DWP is confirmed on a recurrent basis.

STT have connected with the new gambling service and will refer patients on as needed. The gambling service lead (Leads and York trust) came to the PCMH whole team meeting in October 2024 ahead of the clinic opening in Sheffield. The team are aware of referral routes to the service and advise people as well as connecting with local run gamblers anonymous too

STT ask standards questions regarding Alcohol and drug misuse with referral and signposting as appropriate

Professional curiosity sessions have been held for profession specific teams and a joint action plan developed with safeguarding and STT to fulfil responsibilities in relation to domestic abuse.

34. Broader Approaches to Suicide Prevention Work – Interagency Working

At SHSC we adapt to the national and local strategies which inform and influence our suicide prevention work. However, we do not work in isolation. This summary will describe the coordinated and collaborative work with SHSC and partners to raise awareness of suicide prevention, share information, and seek to work across Sheffield to reduce suicide deaths.

35. Suicide Reference Group

The Suicide Reference Group is held bi-monthly and is chaired by the Clinical Risk and Patient Safety Advisor at SHSC. The group has membership from a variety of agencies across Sheffield, and nationally who attend the group to discuss what work is going on locally and nationally.

SHSC engage with our local partners in this group to raise awareness, share information, discuss concerns/trends, and to come together as a group supporting those involved in suicide prevention. The attendees include (but are not exhaustive of):

- Sheffield City Council
- SACMHA
- Sheffield Flourish
- Papyrus
- Amparo
- Crisis House/Listening Ear
- Rethink
- Baton of Hope
- SHSC staff

36. ICB Meetings

Monthly South Yorkshire and national ICB Suicide Prevention meetings are attended where information is shared around strategies, new evidence, concerns or risks for instance. It is these meetings that wider information is shared, and learning can be shared from a variety of sources. Examples of those in attendance at the South Yorkshire ICB meetings includes:

- ICB
- Police
- British Transport Police
- Highways Agency
- South Yorkshire Ambulance Service
- Criminal Justice Agencies

These meetings can be integral to aiding SHSC strategy and information sharing, and much of what is discussed is shared with the wider audiences at Suicide Awareness training and at the Suicide Reference Group, for example. An example of this is around building work related to bridges, where remedial work was conducted by the Highways Agency to improve the safety on certain bridges where data was showing a 'hot-spot' for suicide. Work such as this and the sharing of information adds to the overall strategy and responsiveness within SHSC.

37. Safety Plans

SHSC, Sheffield City Council and Sheffield Flourish developed a Sheffield specific safety plan. There are many safety plans available online, mostly through charities or business ventures. While these are a useful resource, within Sheffield using a variety of safety plans can lead to reassessment of our services users, and an unfamiliarity with those who may be attempting to support those in need.

The Sheffield safety plan is a safety plan for Sheffield, which includes Sheffield specific information for those living in Sheffield. The design of the plan has been developed, funding secured within Sheffield City Council budget, costing agreed with Hive (web designer) and agreement that the plan will be overseen by Sheffield Flourish through their website.

Access is via the Sheffield Suicide Support and Prevention website, and the Sheffield Flourish website. SHSC will play a part in raising awareness of the resource through the above groups, through staff training, and through SHSC communication channels.

The safety plan is available as an interactive form that can be saved and accessed by the service user only, but will also have sharing and printing capabilities built in. The safety plan is also linked to the Sheffield Mental Health Guide resource, which is a comprehensive resource to all services available within Sheffield to support people (and includes Gambling, perinatal and autism support networks). This guide is again hosted through Sheffield Flourish, who is jointly commissioned by SHSC for these services.

SHSC will support Sheffield City Council and Sheffield Flourish to raise awareness of the safety plan, and part of this plan includes ensuring those in the community are aware of the safety plan and how to assist someone in completing the plan, and/or using the plan to seek support if the individual cannot.

38. Real Time Surveillance

In conjunction with the South Yorkshire Integrated Care Partnership, SHSC participates in a Real Time Surveillance system for intervention following suspected suicide. Suicide data from formal external routes, such as coronial inquests and national inquiries, is often subject to delays inherent in due process. In South Yorkshire, we have established a system facilitated by the Police where a death by suspected suicide is notified to involved partners in order that the bereaved can be appropriately supported (being bereaved through suicide is itself a risk factor for suicide) and that appropriate immediate investigation can be undertaken.

Between 2011 and 2021, there were 3,894 patients who died by suicide in a public place, 29% of all patient suicides, and an average of 354 deaths per year. They appeared to be more acutely unwell (with higher rates of schizophrenia and other delusional disorders) and self-harm, drug misuse, relationship break-up and financial problems were more common. Real Time Surveillance works to collate evidence around suicide in public places and addresses potential ways to reduce this with the local area authorities.

39. **Partner Organisations**

Our partner organisations within Sheffield work with us through our ongoing connections and through the suicide reference group. Below is some information around the work in the community with some of our close partner organisations.

Amparo
Amparo is a bereavement service that operates nationally but has branches throughout the UK. Amparo South Yorkshire is a free and confidential service commissioned by Local Authority, Public Health and NHS services in Barnsley, Doncaster, Rotherham and Sheffield to offer free bereavement support across Sheffield, and it is Amparo SHSC signposts for bereavement support. Amparo also offers bereavement support for professionals facing bereavement in their work roles, and this is discussed within the Suicide Awareness Training offer.

SACMHA
SACMHA is a charitable organisation established in 1988 in response to the health and social care needs of people of African and Caribbean descent. SACMHA staff and leaders work closely with SHSC supporting and adding to the improvement of mental services across the board.

SACMHA offers a range of mental health support, including:

- Counselling Referral Service
- Carers Support Service
- Hospital Advocacy
- Hospital In-Reach Service
- Community Support
- Black Men's Group
- Call & Chat Service
- Social Café

SACMHA also champion support in the community around suicide awareness such as The Black Male Barbers Mental Health Project, with its aim is to work with local barbers to develop their knowledge and understanding of mental health related to Black men.

Sheffield Flourish
Sheffield Flourish is a charity that works collaboratively on innovative digital and community projects, recognising the untapped strengths of people who've experienced mental health challenges. Sheffield Flourish and SHSC work together to support a variety of projects across Sheffield, in collaboration with Sheffield City Council.

The recent development of the Sheffield Safety Plan was a collaboration between the three organisations, with Sheffield Flourish leading on the digital development with Hive Digital, a small Sheffield based company who have designed the digital platform for the safety plan.

Sheffield Flourish have a large digital resource available to support those experiencing mental health issues, and their websites include The Sheffield Mental Health Guide, My Toolkit, and Sheffield Suicide Support and Prevention website.

The Sheffield Mental Health Guide is a web-based A-Z of services available in Sheffield (Nationally available services also listed). These services are listed in an easy to access format to allow people to find what support is available for them. This includes services such as gambling addiction, domestic abuse, sexual addiction, drug and alcohol services, counselling support for example.

The Sheffield Suicide Support and Prevention website is a joint website funded by Sheffield City Council's suicide strategy, hosted by Sheffield Flourish. The website focusses on suicide prevention, bereavement, and is linked in with the local and national suicide strategy.

Listening Ear
Listening Ear is a charitable organisation that has a focus on support through counselling and work to help those who've been bereaved, suffered loss or experienced separation. Listening Ear offer specific counselling and support, including age-appropriate bereavement therapy services for children and young people.

Baton of Hope
Baton of Hope is a national charitable organisation that aims to increase awareness of suicide, reduce stigma, and to work with workplaces to raise support available throughout the UK.

Baton of Hope have launched the pledge scheme, where organisations can sign up to be part of the pledge to reduce suicide and raise awareness within our workplaces. SHSC has recently signed up to the Bronze Pledge entry level, and is working with our partners in the ICB to ensure there is alignment within Sheffield.

The pledge has six different sections, which include specifics of:

1. Sign off from senior leadership to support the pledge.
2. Increased awareness across the workplace.
3. Recognising staff who may be at greater risk and providing additional support.
4. Ensuring that lived experience is utilised when writing policy and guidelines for example.
5. Develop the capabilities of staff via training in suicide prevention.
6. Promote the pledge to other organisations and the broader community.

40. Recommendations

The Board of Directors are asked to:

- Note the content of the report for **assurance** and compliance purposes.
- **Approve** the report.
- **Comment** on the report where required.