Safer and Stronger Communities Overview and Scrutiny Committee

25 February 2014

Suicide Audit and Suicide Prevention in County Durham

Report of Catherine Richardson, Public Health Lead

Purpose of the Report

1. This report provides an update on the County Durham suicide rate and provides an outline of responsibilities for Clinical Commissioning Groups (CCGs) and Public Health in relation to suicide.

Background

2. The transfer of commissioning responsibilities to new receiver organisations as a result of the Health and Social Care Act (2012) has implications for the responsibility, management and accountability of suicide audit and prevention.

3. Commissioning of primary and secondary care mental health services is now the responsibility of CCGs. This includes services for individuals with suicidal ideation and the treatment of self-harm.

4. The role of public health is to focus on the whole population with an emphasis on protecting and promoting the public's health, especially around primary prevention. Public health uses aggregated data to understand trends and patterns rather than identify individual patient information. Directors of public health are responsible for monitoring suicide surveillance data from a population perspective and escalating any areas of concern to commissioners and partners. Public health in the local authority is also responsible for commissioning services to prevent suicide. Following the suicide audit undertaken during 2012/13 Durham County Council has commissioned contracts with current providers for suicide prevention programmes including bereavement support, mental health first aid training, relationship support and debt advice for 2013/14.

5. Public Health England (PHE) is the new national agency for public health and will support local authorities, the NHS and their partners across England to achieve improved outcomes for the public's health and wellbeing. Public Health England will provide expertise and support to local areas to help improve outcomes in public health and reduce health inequalities, including mental health and suicide prevention.

6. Health and Wellbeing Boards (HWBs) will be able to support suicide prevention as they bring together key partners including local councillors, CCGs, the Director of Public Health, the Director of Children and Adult services, local Healthwatch and within County Durham key service providers such as the Hospital Foundation Trusts. One of the roles of the HWB is to assess the local health and wellbeing needs and to develop a local strategy to improve health and wellbeing.

7. Within the County Durham Health and Wellbeing Strategy, Objective 4 is to improve mental health and wellbeing of the population. A key action is to develop and implement a public mental health strategy including suicide prevention.

Current position

8. The number of deaths from suicide within County Durham is relatively low compared to other causes of death. Annual rates per 100,000 based upon these relatively small numbers will tend to show significant variation year on year and will produce wide confidence intervals. Pooling data over a longer period (3 years generally) reduces this year to year variability and gives a smoother trend line over time.

9. The mortality rate from suicide in County Durham is highlighted in Appendix 2. A summary of key facts are highlighted below:

- Mortality rates from suicide and undetermined injury is significantly higher in County Durham for men than women (chart 1). This is also true for the north east and England.
- County Durham experienced a significantly higher suicide mortality rate than England for the period 2010-2012 (chart 2). The difference between County Durham and the north east was not significant. Of all north east local authorities in this period only Gateshead experienced suicide rates significantly better than England.
- Mortality rates from suicide and injury undetermined have shown little variation over time in County Durham, the North East or England (chart 3). Due to the relatively small rates over this period the difference is not statistically significant.
- Over this period female rates have been statistically significantly lower than males in County Durham, the North East and England. Neither male or female rates show significant variation over this period (chart 4)

10. As a result of the time lag for national suicide data an annual audit of suicides is undertaken and shared with a range of health and social care partners to inform medium term planning for suicide prevention. This is currently provided by Tees Esk and Wear Valleys NHS Foundation Trust as part of the mental health contract across County Durham and Darlington. The commissioning of this contract has transferred to CCGs.

11. The audit is based on cases which coroners have confirmed as suicide cases and therefore there can still be a 12-18 month time lag between death and reporting within the audit. In light of this delay an additional system has been established in County Durham and Darlington to enable a real time picture of suicide trends to be monitored.

Managing increasing trends

12. In order to ensure that commissioners and providers are able to plan an appropriate and timely response to any increasing trend in suicide and to manage potential emerging suicide clusters, a “real time” alert system has been established whereby coroners and other partners signed up to a protocol and notify the patient safety team in the North of England Commissioning Support Service (NECS), usually within 24 hours of any death where the circumstances suggest it may be suicide.

13. The management of the alert system enables synergy between provider reports of unexpected deaths in services and coroner/partner suicide reports. It has been agreed through the CCG's Quality Forum operating across County Durham and Darlington that North Durham CCG will be the lead CCG on behalf of all three CCGs. NECS will retain responsibility for the management of this system and it is included in the CCG's contract with NECS. The role includes:

- Management of the multi-agency suicide reporting protocol including convening a community response committee.
- Send real time alerts to the CCG identified executive, clinical lead and DPH within 1 working day of receipt.
- Manage a database of potential suicide cases reported through the protocol.
- Participate in cluster/escalation meetings and provide data as required for this process from the database of reported cases.

14. In addition to the above, GP practices as providers have a responsibility to undertake significant event audits (SEAs) where a registered patient completes suicide. It is not proposed that this responsibility changes but the CCG executive and clinical leads are discussing mechanisms to establish local assurance (directly or through NECs) that practices are undertaking SEAs for all potential suicides reported through the alert system.

Recommendations

15. It is recommended that Safer and Stronger Communities Overview and Scrutiny Committee note:

- the current position on suicides within County Durham
- that the responsibility for audit and management of the alert system is now held by the CCG (supported by NECS).
- that suicide community prevention is commissioned by the local authority in line with national guidance and is informed by local suicide information.
- that as a result of the new health & wellbeing structures the accountability of suicide prevention and suicide response will be reported to the mental health partnership Board.

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Appendix 1: Implications

Finance
Suicide prevention services are commissioned from the ring-fenced public health grant.

Staffing
No impact.

Risk
Increasing trend of death by suicide is likely to continue and remain high profile.

Equality and Diversity / Public Sector Equality Duty
No impact.

Accommodation
No impact.

Crime and Disorder
No impact.

Human Rights
No impact.

Consultation
No impact.

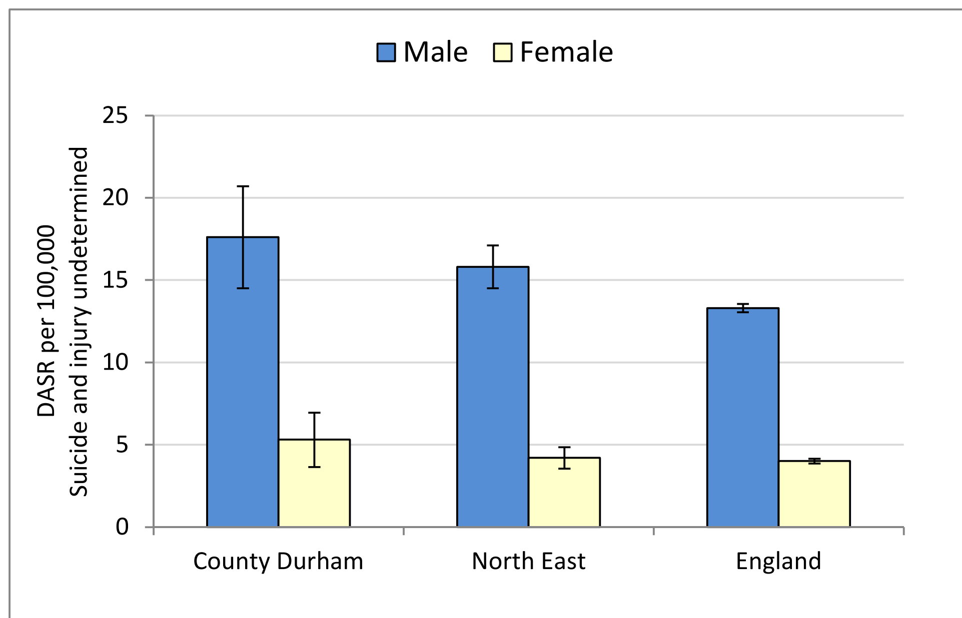
Procurement
Commissioned services are already in place.

Disability Issues
No impact.

Legal Implications
No impact.

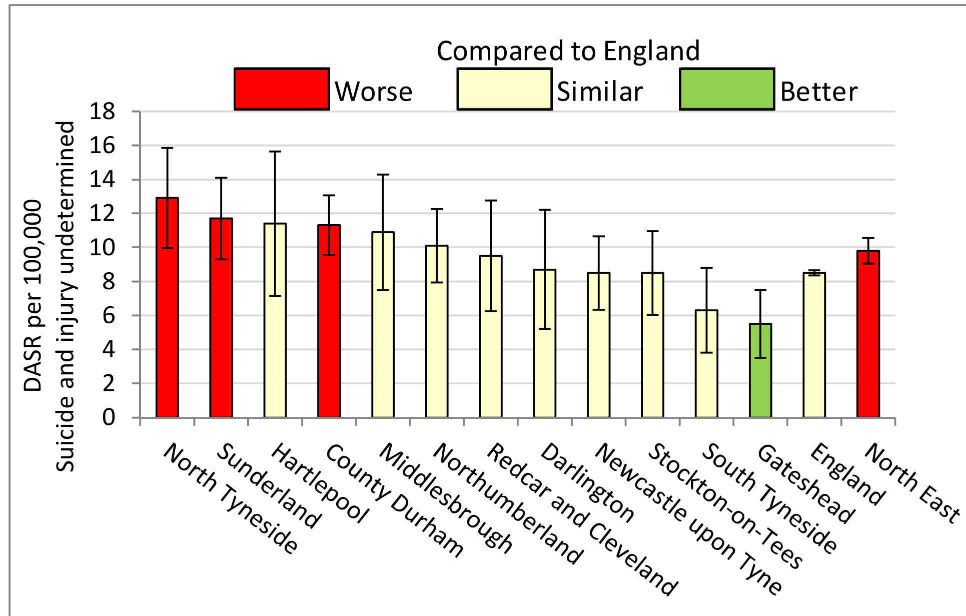
Appendix 2

Chart 1: Age-standardised mortality rate from suicide and injury of undetermined intent per 100,000 population, with 95% confidence intervals, males and females, County Durham, North East and England, 2010-2012 pooled.
Source: Public Health Outcomes Framework



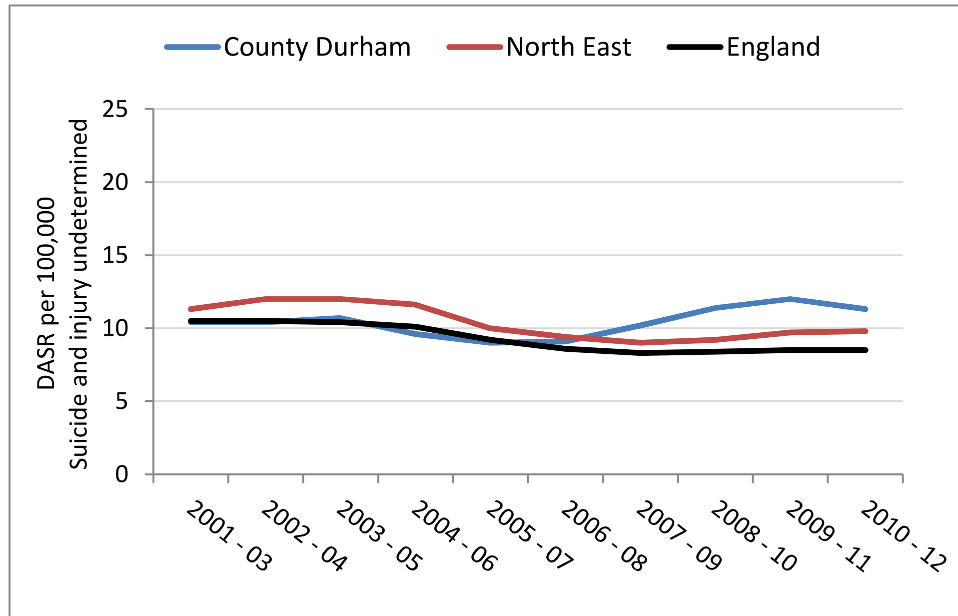
County Durham experienced a significantly higher suicide mortality rate than England for the period 2010-2012 (chart 2). The difference between County Durham and the north east was not significant.

Chart 2: Age-standardised mortality rate from suicide and injury of undetermined intent per 100,000 population, North East Local Authorities, 2010-2012 pooled. Source: Public Health Outcomes Framework



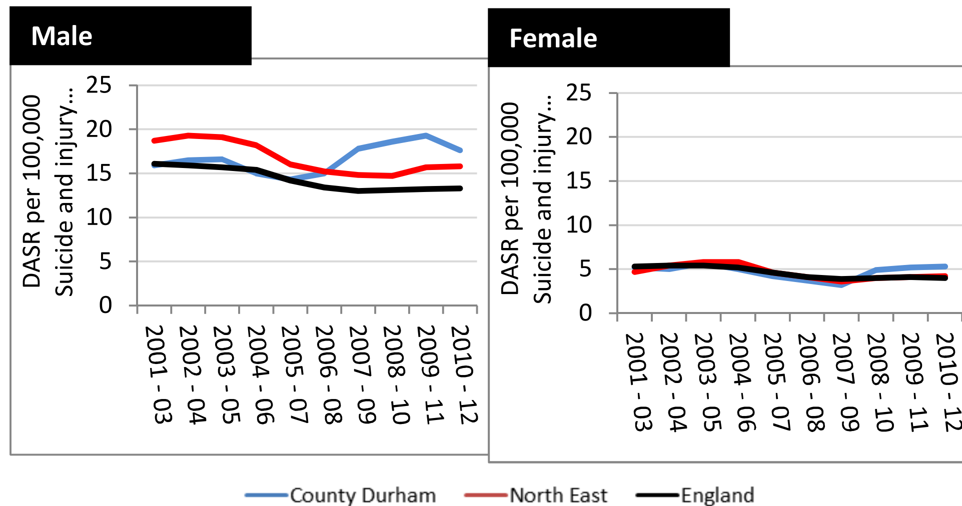
Of all north east local authorities in this period only Gateshead experienced suicide rates significantly better than England.

Chart 3: Directly age standardised mortality rate from suicide and injury of undetermined intent, persons (with 95% confidence intervals), County Durham and England, all ages 2001-03 to 2010-12 pooled.
Source: Public Health Outcomes Framework



Mortality rates from suicide and injury undetermined have shown little variation over time in County Durham, the North East or England (chart 3). Due to the relatively small rates over this period the difference is not statistically significant.

Chart 4: Directly age standardised mortality rate from suicide and injury of undetermined intent, persons male female (with 95% confidence intervals), County Durham and England, all ages 2001-03 to 2010-12 pooled.
Source: Public Health Outcomes Framework



Over this period female rates have been statistically significantly lower than males in County Durham, the North East and England. Neither male or female rates show significant variation over this period.