Greater Manchester Mental Health NHS Foundation Trust

Suicide Prevention Strategy OUR PLEDGE FOR ACTION	
Responsible Director:	Medical Director
Executive Summary:	This Suicide Prevention Strategy provides the Framework and Quality Improvement Plan on how we aim to prevent suicides in our service user population over the next 5 years.
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Contents

1. Introduction

This Strategy will provide the framework of how Greater Manchester Mental Health NHS Foundation Trust (GMMH) intends to learn from best practice and pioneering approaches to assist us in reducing the suicide rates for individuals in our care so that suicide of any service user will be rare.

We know from research by the National Confidential Inquiry into suicides and homicides of people with a mental illness 2015 (NCISH) that approximately 27% of people who die by suicide are under the care of a specialist mental health team. It is therefore these individuals who will be the primary focus for this strategy.

This strategy has been developed in consideration to best practice approaches to patient safety such as those highlighted in Professor Don Berwick's report 'Improving the Safety of Patients in England' 2013, who advocated the importance of credible role models and effective leadership at board and ward level in successfully embedding an open and transparent patient safety culture across the organisation.

Consideration has also been given to pioneering approaches such as the Detroit Model developed by Henry Ford in Detroit. The Detroit model developed on the philosophy of 'Perfect Depression Care' has seen a significant reduction in the overall suicide rates to 75% over 4-years and to some years without a single suicide. We also aim to learn from approaches developed by our neighbouring organisations in Cheshire and Merseyside who we know have adopted the Canadian 'Suicide Safer Community' model through the collaborative working of all agencies to prevent suicide rates across the community.

1.1. Aims of the strategy

GMMH Executive board have identified Senior Clinical Practitioners who are committed to embedding a safety culture across the organisation who will have responsibility for coordinating delivery of the quality improvement plan supporting this strategy and who will monitor progress against the strategic priorities.

GMMH will continue to develop its reputation as a learning organisation where staff, service users and carers feel able to tell us their concerns so we can continue to learn and make improvements to the care we provide.

We aim to create an organisational culture of resilience amongst our front line staff and service user population where safety is fundamental to clinical practice. Where suicide will be viewed by teams as avoidable and not inevitable and where staff feel supported and confident to communicate openly with Service Users, Carers and families so that suicide is not the only solution our service users feel they have in order to respond to their difficulties.

Managing the risk to service users is a central concern in the day-to-day lives of our front line staff. Positive risk management as part of a carefully constructed plan of care

is a required competence for all mental health practitioners (*DoH recommendations for best practice in risk management 2002*). A key element of this Strategy will be on developing staff to feel confident in their decision making during their day to day practice in incorporating Positive Risk Management into an individual's recovery plan.

We recognise that suicide prevention is not the sole responsibility of one agency. Suicide prevention requires a whole community and regional approach. This Strategy therefore has to be viewed as integral to the work achieved through the strategic approaches across our wider Public Health and Social Care Community, and other key partners such as the Police, Fire and Rescue ~~for~~ whom GMMH is committed to working with collaboratively in order to prevent suicides across our region. This Strategy should therefore be seen as one of a number of strategic approaches to be integrated to prevent suicides across our region. The other Suicide Prevention Strategies are those of our wider Public Health and Social Care Communities including Police, Fire and Rescue and voluntary groups. GMMH is committed to collaborate with all these agencies within our region.

1.2. Rationale for this strategy

Suicide is an important public health issue. In the UK, one person dies every two hours as a result of suicide and twice as many people die from suicide than from road accidents every year. Globally over 800,000 people die due to suicide every year and suicide is the second leading cause of death worldwide in 15 – 29yr olds.
(World Health Organisation- *Preventing Suicide: A global imperative 2014*)
The impact on family and friends can be devastating with evidence suggesting that family and friends are then up to 3 times more at risk of taking their own lives.

In the UK and Ireland, there were 6,581 suicides in 2014. According to national guidance and research in the UK, the number of suicides in men, particularly between the ages of 45 to 59 years, a markedly increased, with the data suggesting that men are three times more likely to take their own life than women are. (*Samaritans suicide statistics report 2016*). It is important to note however, that recent research suggests that the number of suicides in women has also increased.

A recent study by Doyle et all 2016 into Suicides whilst under Primary Care found that individuals with a diagnosis of Personality Disorder already associated with elevated suicide risks found that these individuals had a 20 fold increase in suicide risk compared to those individuals without this diagnoses, this risk increased where there was a comorbid alcohol misuse. The study also found a relative risk being higher in females than males.

We know from our local data that 77% of suicides from between 2003 to 2015 were by men in their forties. 46% of these suicides died within one week of their last contact with us. 65% of these had a history of self-harm and just over half had a drugs or alcohol problem. These findings will form key drivers for action as part of this strategy.

This strategy will be aimed at all ages in recognition that age appropriate interventions are important for addressing the needs of both our adult service users and the young

people in our care. This strategy will specifically focus on the prevention of suicide rather than the related problem of non-fatal self-injury. Although we recognise that people with a history of self-harm are identified as a high risk group and trends in self harm and suicide can be closely related, this strategy will not specifically focus on the causes and care of self-harm. This strategy will however promote best practice interventions and tools to assist staff in supporting those individuals who do self-harm.

Most people who take their own life have never been in contact with mental health services but it is well known that mental illness is one of the major factors increasing an individual's vulnerability and risk associated with suicide. According to the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) annual report 2015, suicide by users of mental health services has risen in England. Research by NCISH has shown that a quarter of individuals who die by suicide have seen mental health services in the year before their death. Around 5% of patient suicides occur in those who are in receipt of in-patient treatment.

High unemployment and severe economic problems can have a significant impact on an individual's mental health. The stigma associated with mental illness is also known to have a detrimental effect resulting in individuals who may be at risk from avoiding seeking help from professionals. As part of this strategy, we aim to raise awareness amongst our workforce, service users and carers around the stigma of Mental Health. We want to raise the focus on suicide with the aim of reaching out to those individuals who we know are more at risk of suicide such as men in their forties and fifties who live alone and who may misuse drugs or alcohol, or individuals in our care who self-harm to deal with stressful events in their life.

1.3. Vulnerable groups and those most at risk

According to national research, some populations are at higher risk than others.

- Middle age men aged between 45-59years
- People known to mental health services
- People who misuse Drugs and alcohol
- People with a history of self-harm
- People who have made previous suicide attempts
- Young people who are looked after
- People in contact with criminal justice system
- Veterans
- Lesbian, gay and bisexual and transgender people
- Black British, Eastern Europeans and ethnic minority groups
- Those who are unemployed or on long term sickness
- Specific occupational groups such as doctors, nurses, veterinary workers, and farmers

Stressful life events can also play a part; these may include:

- Loss of a job
- Guilt and shame

- Debt
- Living alone or becoming socially isolated
- Bereavement
- Family breakdown and conflict including divorce
- Imprisonment

1.4. Suicides in young people

According to a recent study by NCISH relating to suicides by children and young people ‘May 2016 over a 12-month period.
There were 145 suicides and probable suicides by children and young people in under the age of 25 in England between January 2014 and April 2015.
The main findings of this study found that the key themes in suicide by young people were:

- Family factors relating to mental illness
- Abuse and neglect
- Bereavement and experience of suicide
- Bullying
- Suicide –related internet use
- Academic pressures especially related to exams
- Social isolations or withdrawal
- Physical health conditions that may have social impact such as Acne or Asthma
- Alcohol and illicit drugs
- Mental ill health, self-harm and suicidal ideas

  Suicide rates in this age group are overall low but the highest levels being in the later teens with the majority of deaths being males (70%).

Some Key findings

- 32% of the young people were in a relationship at time of death
- 19% had a relationship breakup in the 3 months prior to death and 25% had relationship problems in that period.
- 36% had family problems in the 3 month prior to death and 5% had experienced parental separation or divorce.
- 28% had experienced bereavement
- 13% had been bereaved by suicide
- 22% had been a victim of bullying
- 15% had been socially isolated
- 10% were reported as having recently become socially withdrawn
- 12% search the internet for information on suicide

1.5. Key messages from this study

Many young people who die by suicide have not expressed recent suicidal ideas. An absence of suicidal ideas cannot be assumed to show a lack of risk.

The Multicentre Study of Self-harm has suggested a recent increase in self-harm in younger age groups despite an overall fall in the last 10 years - Self-harm is a key indicator of suicide risk and the reported rise has highlighted the need for better services and more positive experiences of care for young people in crisis. Improving the mental health of young people now is key to suicide prevention in the long term.

A wide range of mental health problems are associated with self-ham including borderline personality disorder, depression, bipolar disorder, schizophrenia and drug and alcohol misuse. Individuals who self-harm have a 50- to 100 higher likelihood of dying by suicide in the 12-month period after an episode than people who do not self-harm. We know that the transition between services e.g. from services for young people to services for adults can be difficult period for any individuals but is particular so for those individuals who self-harm. We need to ensure we have plans in place to manage these transitions of care so that service users do not feel isolated and unsupported increasing their risk of self-harm. These plans need to be created in collaboration with the professional and the service user in identifying what support they require and who to contact in a crisis. *NICE quality standard Self Harm QS34 -2013*

It is important to note that for any individual it can be a combination of factors and events rather than one single factor that can increase a person's vulnerability to suicide. In clinical practice, the history of self-harming behaviour and suicide attempts, current presentation of the patient, current context and availability of protective factors are most important when assessing, formulating and managing risk. The factors leading to someone taking their own life as mentioned above are often complex, however GMMH believe all these factors are amenable to change.

Local Data (The following data seen in Table 1 below was provided for this strategy by NCISH)

According to the National Confidential Inquiry between the periods January 2003 to December 2013 there were:
52,848 suicide and probable (open verdict) suicides in England and Wales (based on date of death).
14,333 (27%) of these suicides and probable suicides were in contact with mental health services within one year prior to death. In the same period, there were 830 suicides and probable suicides within the geographical areas served by the Trust

232 (28%) of these suicides and probable suicides, had been in contact with the Trust within one year prior to death.

Table 1

Year	**2003-2013**	
	Trust figures	**England & Wales**
Data available on all of those in contact with services in **Greater Manchester West Mental Health NHS Foundation Trust** within one year prior to death ***Percentages given are valid percentages***	232	14,101
Age Median (Min-Max)	42 (15-89)	45 (10-98)
Sex Male **	179 (77%)	9,532 (67%)
Female **	53 (23%)	4,801 (34%)
Ethnic origin		
White	218 (94%)	12,929 (90%)
Black & minority ethnic group	14 (6%)	1,404 (10%)
Employment status		
In paid employment	37 (17%)	2,743 (20%)
Unemployed **	115 (53%)	5,944 (43%)
Housewife/husband *	< 10	599 (4%)
Full-time student	< 10	211 (2%)
Long-term sick	35 (16%)	2,122 (15%)
Retired	25 (12%)	2,035 (15%)
In-patient at time of death	18 (8%)	1,367 (10%)
Died within 3 months of discharge from in-patient care	38 (18%)	2,496 (19%)
Refused drug treatment in the month before death	25 (13%)	1,768 (14%)
Missed last contact with services *	39 (19%)	3,298 (26%)
Primary diagnosis		
Schizophrenia & other delusional disorders	35 (15%)	2,465 (17%)
Affective disorders **	70 (31%)	6,424 (45%)
Alcohol dependence/misuse	24 (11%)	1,165 (8%)
Drug dependence/misuse **	53 (23%)	604 (4%)
Personality disorder	13 (6%)	1,264 (9%)
History of self-harm	148 (65%)	9,585 (68%)
History of violence	58 (26%)	3,013 (22%)
History of alcohol misuse	114 (51%)	6,338 (45%)
History of drug misuse **	120 (53%)	4,544 (33%)
Last contact with services within 1 week before death	106 (46%)	7,013 (50%)

There were **9** significant differences between our Trust and England and Wales overall, for the time period specified (denoted by * or **). Compared to the national sample, The Trust as a proportion of all patient suicide deaths had significantly:

- More patient suicides who were male.
- Fewer patient suicides who were female.
- More patient suicides who were unemployed.
- Fewer patient suicides who were a housewife / husband.
- Fewer patient suicides who missed their last contact with services.
- Fewer patient suicides who had a primary diagnosis of an affective disorder.
- More patient suicides who had a primary diagnosis of drug dependence / misuse.
- More patient suicides who died by self-poisoning.
- More patient suicides who had a history of drug misuse.

Suicide prevention is a complex and challenging task, which requires a co-ordinated, and multi-agency approach. In order to be effective suicide prevention strategies should be directed towards a number of factors in reducing the risks of suicide occurring e.g. availability of dangerous means and recognising and supporting high-risk groups such as men in their forties and fifties and individuals with a mental health problem and or drugs and or alcohol problem which we know has been an indicator for those deaths occurring in a number of our service users found to have taken their own life.

Priority areas for action

Based on evidence and our analysis of national and local data GMMH have adopted 5 priority areas as the key drivers for quality improvement across the organisation.

- ***Care will be evidence based, timely, safe and effective***
- ***Partnership working***
- ***We will support Carers and Staff when they have been bereaved or affected by suicide***
- ***We will be a learning organisation***
- ***Competent workforce***

Progress on the quality improvement plan supporting this Strategy will be reviewed quarterly by the Trust Suicide Prevention Group and in partnership with our commissioners through local Quality Governance forums.

OBJECTIVE 1. Care will be evidenced based, timely, Safe and Effective	**Actions**
	1. Identified Suicide Prevention Practitioners from each clinical area will become key members of the GMW Suicide Prevention Strategy Group with responsibility for implementation of the key priority areas within the strategies quality improvement plan with focus on reducing the risk of suicide for the following high risk groups • Individuals who self-Harm • Men • Individuals with a diagnoses of Personality disorder • Individuals with Mental illness and drugs and alcohol co-morbidity • Service users within our criminal justice services
	2. Review wider Multi agency membership at GMW Suicide Prevention Strategy Group and agree dates for monitoring of progress against Strategy improvement plan
	3. Develop Trust Wide Self-harm Policy and Self Harm Tool kit for front line staff to access to improve their skills when working with individuals who self-Harm.
	4. To explore service models around development of identified skilled Self-Harm Practitioners within A&E liaison teams and RAID teams
	5. Service Users at risk of self-harm or suicide will have a safety plan in place agreed in collaboration with the Individual Practitioner, Service User, Carer/Family and GP and other key professionals involved in their care before discharge from hospital
	6. Positive Support Plan template to be agreed and piloted before launching trust wide in out A&E liaison and RAID Teams

	7. Explore our local arrangements for improving timely and effective follow up following inpatient discharge e.g. introduce wellbeing telephone call within 48hr of in-patient discharge ,
	8. Review local arrangements for monitoring and follow up of service user DNA rates within our Drugs and Alcohol services
	9. Explore effective ways of ensuring timely and accurate information is sent to GPs in relation to an individual's onward care and treatment plan following discharge to include individuals discharge plan, Safety plan and Medication summary
	10. The use of 'Zoning' will be embedded into the practices of all CMHT/Home Based Treatment Teams using a traffic light approach to ensure teams can target resources and Safety Plans for those individuals assessed as higher risk of self-harm and suicide. This will result in increased monitoring of those individuals
	11. We will continue to review our Safe Medicines Management practices to ensure Service users are closely monitored and where those at higher risk will have reduced, take home medications or supervised consumption to reduce access to lethal doses. An audit of these safer practices will form part of our annual audit programme for 2017/18
	12. We will continue to ensure newly designed services and existing services are safe through continuation of our annual inpatient ligature point's reduction and audit programme.
Objective 2 Partnership working	**Actions**
	13. Explore opportunities to review joint approaches with our Acute Providers and Primary Care partners (GPs) around improved pathways during transitions of care for those high risk individuals highlighted in this strategy e.g. pathways between inpatient services, Drugs and Alcohol, A&E, CMHT/HBTT
	14. Explore opportunities of partnership working with GPs and A&E teams in developing training packages to develop specific clinical skills around Mental Health, Self-Harm ,Personality Disorder and Suicide Prevention and safety Plans
Manchester Suicide Preventio	15. We will be a key partners and have representation at the Manchester Suicide Prevention Network and Manchester Suicide Prevention Group in contributing to the Manchester's 9 pillars priority areas

n Group (CQUIN)	
	16. The Trust Suicide Prevention Strategy will be aligned with GMMH following January 1st acquisition and to include Manchester Suicide Prevention CQUIN targets
	17. Staff Representatives from our Manchester Services will join the GMMH Trust suicide Prevention Group
	18. We will contribute to Manchester Suicide Prevention Strategy 9 pillars priority areas for action with specific reference to delivery of pillar 6 of the Manchester Suicide Prevention strategy 'Suicide intervention and ongoing clinical support services' key areas will be discussed at the September 2017 Manchester Suicide Prevention Group
	19. We will work with key partners in exploring pathways into appropriate community support for our services users
	20. We will work with key partners in exploring initiatives that provide support for people in distress and managing distressing thoughts
	21. In collaboration with our staff, Service Users and Carers review our public facing Trust Website in relation to information and support for Service Users, Members of the Public and staff in relation to Mental health and wellbeing and Suicide awareness
OBJECTIVE 3 We will support Carers and Staff when they have been bereaved or affected by suicide	**Actions**
	22 Commission a new Bereavement Liason Nurse role to support staff and carers who have been affected or bereaved by a suicide
	23 .We will continue to Open and Honest in line with our statutory Duty of Candour obligations and engage with Carers throughout our SUI process, Our Carers will be offered a copy of the SUI report prior to the inquest hearing.

	Sample of cases to be audited to demonstrate compliance with Duty of Candour statutory obligation
	24 Post Vention- We will explore post suicide interventions and support for Carers and staff through developing partnerships with our local voluntary groups such as SOBS and Samaritans, PAPYRUS from a young person's perspective and local sports and recreational groups in relation to building resilience for our male service users and staff.
	25. We will Increase the numbers of trained practitioners across the Trust delivering a timely Post Incident Debrief service to staff following a traumatic incident such as the unexpected death of a service user by suicide.
	26. Front line staff will receive Bereavement Awareness Training so they can support carers and colleagues affected or bereaved by suicide
	27. Annual Monitoring of Compliance against staff Supervision Policy in order to embed the importance of support for staff via clinicians supervision
OBJECTIVE 4. We will be a learning organisation	**Actions**
	28. The Trust Mortality Review Group will have responsibility for: • Reviewing of reliable and timely SUI data and Thematic reviews, Serious Incident Reviews and Coroners to monitor numbers of deaths each quarter quickly identify Peaks, trends and hotspots, and action required • monitoring incident Data quarterly in relation to number of deaths by suicides escalating according to trust board • Disseminate the learning from this group Trust wide
	29. Multidisciplinary Positive Learning Events will be held within 2 month following the suicide of a service User in our care so learning is shared across teams in timely manner Assurance of this process to be via annual audit programme
	30 Front line staff will complete an anonymised Suicide Prevention Survey to help us review staff perceptions and confidence levels in caring for individuals who are at risk of suicide, with a view of tailoring training programmes accordingly

	31 . To lead on benchmarking activities with neighbouring partners /organisations in relation to improving service user experience and outcomes
OBJECTIVE 5 COMPETENT WORKFORCE	**Actions**
	32 We will invest in STORM training for 100 clinical staff to include the following roles Clinical Risk Trainers, Ward Managers Team leaders and Advanced Practitioners
	33. Clinical Teams will be trained in use of Safety Plans'
	34. All qualified front line staff will receive Clinical risk training via e-learning within the first 6 month of them commencing in role and face to face every 3 years there after
	35. The Trust will hold a Suicide Prevention conference for staff, Carers/Families and key partners

Quality Measures

1. Annual audit programme to include following audits

- Number of Positive Support Plans in place following Training
- Self-harm in line with current NICE - Self Harm Quality Standards following development and launch of Self Harm policy
- Being Open process and sharing SUI review with Carers/family
- Learning Lessons following SUIs/Complaints & Inquests
- Number of Positive Learning Events following SUI review within agreed timelines
- Follow up post discharge from hospital e.g. wellbeing call and face to face contact
- Annual In-Patient ligature audit and ligature Point Reduction Programme
- Monitoring and follow up of service user DNAs within drugs and Alcohol services

2. Monitor Clinical Risk Training compliance figures

3. Review the recommendations following the Salford pilot of improving experience of service users with a drugs and alcohol problems under the care of the CMHT with a view of sharing this learning trust wide for consideration into future service development of this service user group
4. Evaluate STORM Training
5. Monitoring of Number of Suicides year on year 6. Number of serious Self Harm Near Miss incidents
7. Monitor Training compliance figures on following training programmes • Clinical Risk Training • RCA and SUI review process
8. Complete Evaluations on: • PIDS process and staff feedback • Bereavement support service staff and carer feedback

2 Duties

Trust Board responsible for

- Overseeing the Suicide Prevention strategy and ensuring adequate resources are allocated to allow the organisation to achieve its goal of significantly reducing its suicide rates amongst its service user population.
- Monitoring progress of the identified quality improvements via its sub committees and associated governance frameworks.
- Setting the tone of the organisation that promotes a just culture that avoids blame and where staff feel safe and supported.
- The Trust Quality Governance Committee is delegated from the Board to monitor the progress of the strategy

The Medical Director will be the Lead Executive Director for this Strategy will have responsibility for:

- Implementation and reporting to the trust board on suicide related activity.
- Providing overall clinical leadership in promoting a trust safety focused culture where suicides are deemed preventable.
- Chair of Suicide Prevention Strategy Group.

Head Of Patient Safety and Governance will have responsibility for:

- Development of this strategy and Quality Improvement Plan.
- Coordination of the Trust Suicide Prevention Strategy Group who will monitor implementation of this strategy and quality improvement plan.
- Deputy Chair of Suicide Strategy Group.
- Providing quarterly progress reports to QGC
- Providing quarterly CQUIN updates to Commissioners in relation to progress against the quality Improvement plan supporting this Strategy

Senior Clinicians will have responsibility for:

Providing clinical leadership across there clinical areas in driving forward a safety focused approach to care and ensuring suicide prevention interventions are promoted within the practices of local multidisciplinary teams.

Senior Managers will have responsibility for:

Ensuring staff are made aware of this strategy and the key priority areas within the quality improvement plan are implemented locally.

- ensure staff have access to the support and training made available in relation to this strategy and suicide prevention.

All qualified Health Care professionals will have responsibility for:

Accessing support and training in relation to this strategy and suicide Prevention agenda.

- Implementing key elements of this strategy such as Positive Support Plans and relevant clinical risk management standards and practices.
- Ensuring suicide prevention is embedded into their individual practice and local team culture.

All Trust staff will have responsibility for:

Reading this strategy and following the principles outlined in maintaining the safety of the service users in their care

- Accessing any support and training made available to support this Strategy and quality improvement plan.

3 Training Requirements

Training in relation to this strategy will be carried out in accordance with the Trust Organisation Wide Training Needs Analysis (TNA).

3.1 Monitoring

Frequency	Process for monitoring	Evidence	Responsible Individual(s)	Response Committee(s)
Quarterly	Monitoring of strategy Quality Improvement plan	Progress against action plan	Head of patient Safety and Governance	Suicide Prevention Strategy Group
Quarterly	Chairs report		Medical Director	QGC
Quarterly	Performance monitoring Progress report	CQUIN evidence	Head of patient Safety and Governance	Performance measures group

3.2 Requirements

Board Objective	• Objective 1: We will work with local communities and organisations to improve the quality of life of our service users • Objective 2: We will give our service users high quality and effective care when and where they need it • Objective 3: We will support all our staff and encourage excellence and new ideas • Objective 4: We will provide services in safe, clean environments that are easy to get to and support our users' needs
CQC Standards	• Involvement and information • Personalised care, treatment and support • Safeguarding and safety • Staffing and support • Quality and Management

3.3 Supporting Documents and References

- 2012 Suicide Strategy for England ***'Preventing Suicide in England a cross-government outcome strategy to save lives'***
- The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Annual Report July 2015
- 2015 NHS Outcomes framework

- Office of National statistics 2012
- *Safer Mental Health services toolkit* NCISH April 2013
- *Twelve points to a safer service* 2012
- NCISH '*Young People and Suicide* in England 2016
- Zero Suicide: *An international Declaration for Better Healthcare* March 2016
- NICE Guidance for Self-Harm 2013
- DoH Recommendations for best practice in risk management 2002.
- *Patient Suicide: impact of service change* November 2013
- '*improving the safety of patients in England* 2013 Professor Don Berwick
- '*Suicide Risk in Primary Care patients'* Doyle et al BMC Family Practice 2016

4 Feedback

Please direct any questions in relation to this document to Julie Bodnarec Head of patient Safety and Governance Julie.bodnarec@gmmh.nhs.uk

5 Review

This document will be reviewed regularly by the Suicide Prevention Strategy Group in accordance with organisational, legislative or other changes.

The Trust Quality Governance Committee is delegated from the Board to monitor the progress of the strategy

To ensure that this strategy does not discriminate unfairly against any particular group across GMMH, an equality impact assessment will be undertaken during drafting process,