LEICESTER CITY HEALTH AND WELLBEING BOARD
DATE

Subject:	Leicester, Leicestershire and Rutland Suicide Prevention Strategy
Presented to the Health and Wellbeing Board by:	Mark Wheatley
Author:	Mark Wheatley

Does the report concern any of the below groups?			
Severe Mental Illness	Learning Disability	Homelessness	Care Experience Children and Young People
☐	☐	☐	☐

EXECUTIVE SUMMARY:

The Leicester, Leicestershire and Rutland Suicide Prevention strategy sets out the ambitions of the local Suicide Audit and Prevention Group (SAPG) to promote partnership to build on current efforts to support people at risk of death by suicide and people who have been affected by suicide.

The strategy is informed by past local action, and the national suicide prevention strategy for England. It has been subject to consultation at every stage to identify priority groups, suicide risk factors and supportive actions. In the last year the SAPG has consulted with individuals, meetings across local authorities, the NHS, voluntary, community and social enterprise sectors and the public.

This paper sets out the results of the public consultation held October – December 2024, and the amendments to the draft strategy.

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to:

- Note the consultation on the forthcoming LLR Suicide Prevention Strategy and comment on the draft strategy

1. Summary

Update on the consultation on the draft suicide prevention strategy refresh for Leicester, Leicestershire and Rutland (LLR).

2. Recommended actions/decision

Leicester Health and Wellbeing Board is recommended to:

- Note the consultation on the forthcoming LLR Suicide Prevention Strategy and comment on the draft strategy

3. Scrutiny / stakeholder engagement

3.1 The writing and delivery of the draft LLR suicide prevention strategy has been overseen by a Steering Group, which also includes people from statutory, voluntary and community sector organisations and people with lived experience.

3.2 The initial draft of the LLR Suicide Prevention Strategy was made in consultation with interested people and organisations across LLR. Those consulted included people from statutory, voluntary and community sector organisations and people with lived experience of suicide (that is people who've survived suicidal thoughts and acts) and people who've lost someone close by death from suicide.

3.3 With regard to stakeholder and political consultation, the draft strategy was presented at the following meetings:

- ICB Operational Delivery Group (22nd October 2024)
- Leicester City Council Public Health and Health Integration Scrutiny Commission (5th November 2024)
- Leicestershire Health Overview and Scrutiny Committee (13th November 2025)
- ICB Urgent and Emergency Care System Group (14th November 2024)
- Best Practice Reference Group (14th November 2025)
- LLR Mental Health Collaborative (25th November 2024)
- Rutland Council Strategic Overview and Scrutiny Committee (28th November 2024)
- Autism Partnership Board (10th December 2024)
- LLR ICS System Quality Group (19th December 2024)
- Rutland Health and Wellbeing Board (14th January 2025)

3.4 The draft strategy was received positively, with an appreciation for the level of work that goes into suicide prevention, acknowledging limited resources and budgetary constraints. In these meetings there have been questions and discussions surrounding activities and broader mental health aspects, such as how to address loneliness and isolation, as well as how to record suicide attempts.

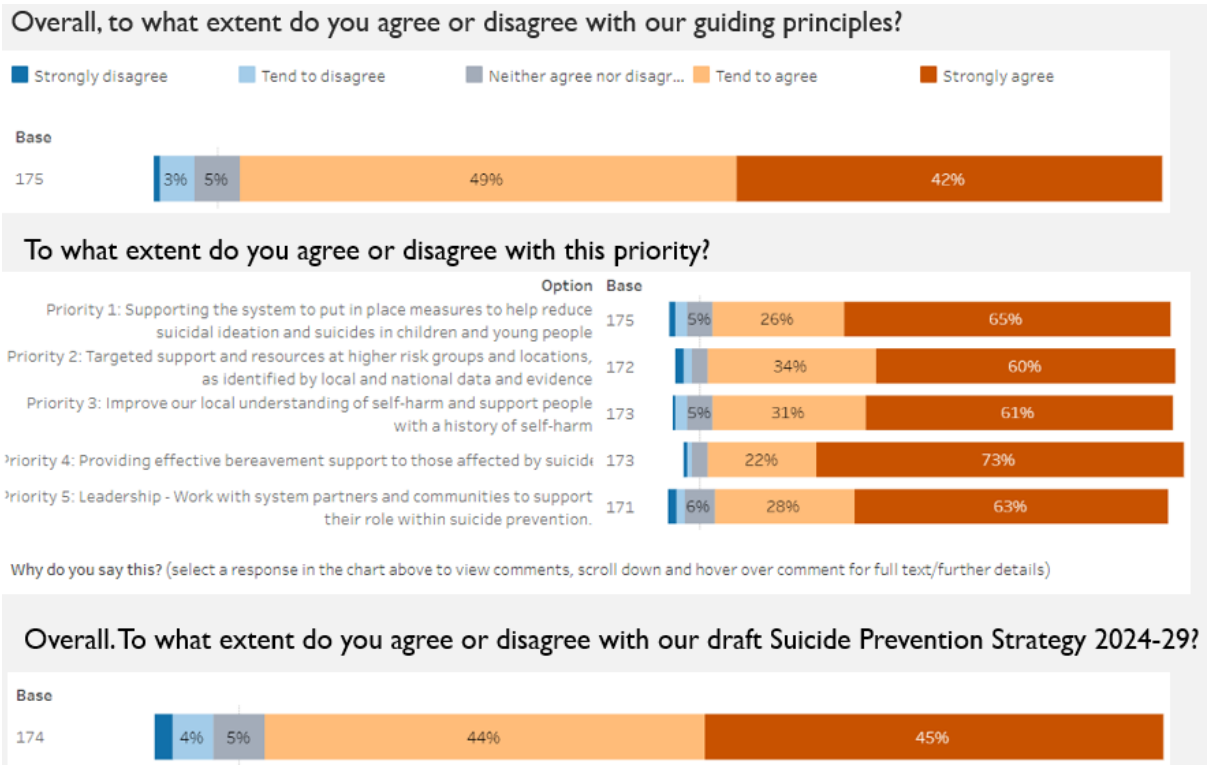
3.5 The strategy has also been subject to a full public consultation, held 28th October - 22nd December 2024. This consisted of an online survey and focus groups with residents who have lived experience of suicide, as well as the Youth Advisory Board within LPT.

3.6 The consultation summary is attached as Appendices 1 and 2.

4. Background and options with supporting evidence

4.1 There were 176 responses to the online survey. Figure 1 shows that these were overwhelmingly positive about important aspects of the draft strategy such as the underlying principles of the approach (briefly summarized as suicide prevention is 'everybody's business'), the priorities and overall approach.

Figure 1: Responses to the online consultation survey for the LLR Suicide Prevention Strategy October – December 2024

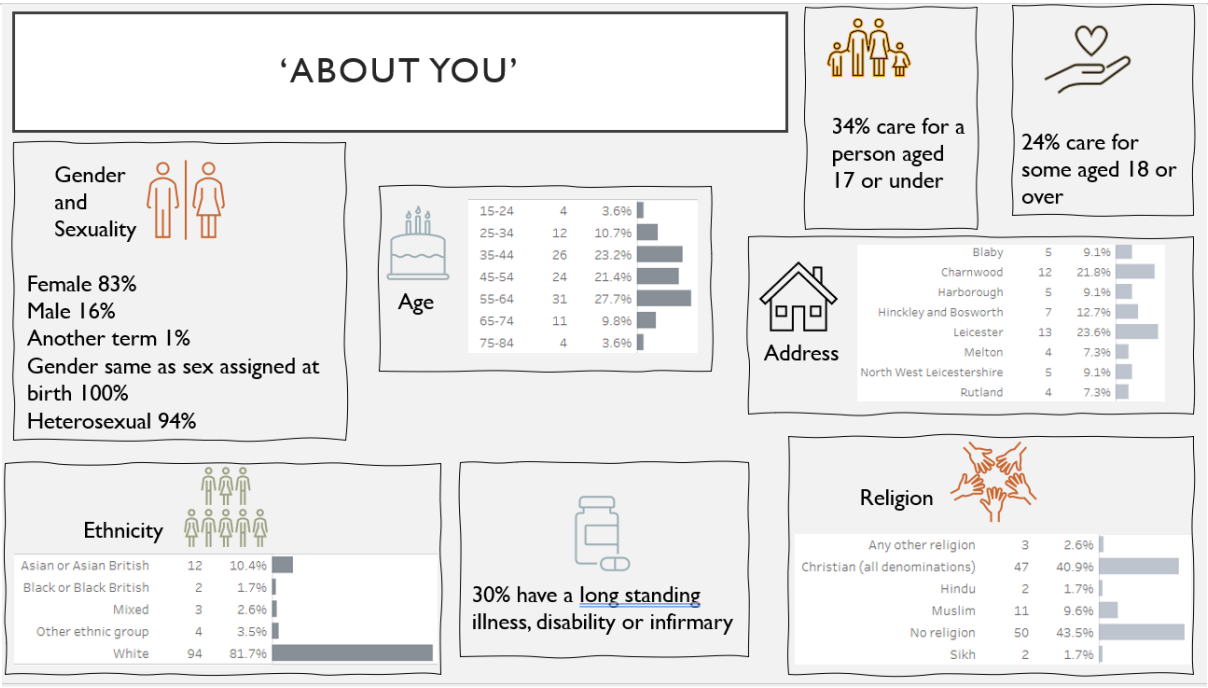


4.2 Figure 2 shows the demographic make-up of respondents who answered the 'About You' questions at the end of the survey. Although the data needs careful interpretation, for example, only 31% of respondents answered the question around where they live, it is possible to describe some key characteristics of the respondents:

- They were well spread across different age groups.
- They were predominantly female (83%); possibly highlighting the challenges faced in engaging with men on the topic of mental health and suicidal thoughts.
- 34% cared for someone aged under 18, and 24% caring for someone aged 18 or over.

4.3 24% (n=42) stated that they have accessed formal support for mental health within the past 12 months, with 61% (n=107) having lived or living experience of suicide.

Figure 2: Demographics of the respondents to the online consultation survey for the LLR Suicide Prevention Strategy October – December 2024



4.4 Some feedback focused on tangible ideas and solutions which could help reduce and prevent suicide, rather than on the strategy itself. This will be used to inform the development of the action plan.

4.5 Overarching themes and topics from the consultation included:

- Raising awareness of suicide prevention is a key activity.
- The importance of early prevention, for instance conversations about protecting mental health could start in primary school, and openness about suicide.
- Lack of funding for suicide prevention work and services.
- Long waiting times for mental health services, which can impact suicide.
- Lack of support for those in crisis and those who are mentally unwell but not at crisis point.
- Better co-ordination between services and organisations required to ensure person centred care.
- Ensure a wide range of organisations and services are involved
- Signposting should be improved due to a range and variety of available services and no single point of access.
- Provide training to relevant individuals or organisations to make sure suicide prevention is everybody's business.
- Make use of data from a range of sources including voluntary and community sector.
- Address the wider determinants of suicide and tackle those issues e.g. quality of mental health services, personal finance, gambling.

- Proportionate universalism – respondents felt that there should be services for all, however there should be extra support to those groups in higher need and at greater risk.

4.6 Some remarks on the final strategy and action plan

4.6.1 As there was high level of agreement within the consultation, the final strategy has not changed dramatically from the initial draft (see Appendix 3)

4.6.2 Document changes include facts and figures on risks linked to substance use, harmful gambling and domestic abuse.

4.6.3 The consultation highlighted vulnerabilities to suicide among some people which are not demonstrated in local data, but do feature in the broader literature, including LGBTQ+ people, Gypsy or Irish Travellers and those experiencing the menopause.

4.6.4 The guiding principles have largely remained the same, with some extra wording added to reflect the need to understanding the intersectionality of factors and recognising the importance of cultural appropriateness (alterations written in red):

a. **Co-Production and Collaboration**
    i. Meaningful and authentic lived experience involvement will underpin everything we do and will be viewed as an essential part of delivering effective services and interventions.
b. **Learn from past stories**
    i. We will seek to understand our local suicides and the intersectionality of contributory factors, including wider determinants of health such as social and economic challenges. Future work will be shaped by this and informed by the realities of those affected.
c. **Data driven**
    i. Our work will be driven by our understanding of a wide range of local data, and the current and emerging evidence base to reduce suicides. We will target our work using data and evidence, ensuring we reach those that need help the most.
d. **Normalising conversations**
    i. We will strive to reduce stigma and taboo around suicide and mental health and encourage people to Start a Conversation. This will be instrumental to all of our work and our priority areas. We will ensure approaches are culturally appropriate and sensitive, recognising and respecting diverse needs, values and beliefs in our communities. We will work with local media on aspects of mental health and suicide, ensuring stories are portrayed sensitively and safely, in line with current guidance, and challenge inappropriate reporting and conversations where necessary.
e. **Settings-based approach**
    i. We will adopt a settings-based approach to integrate suicide prevention activity into local communities, organisations and sectors, emphasising education, awareness and training, with a strong focus on early intervention, and local leadership.
f. **Trauma Informed Practice and Care**
    i. We will work to adopt a Trauma Informed Approach in our interactions, delivery and commissioning: understanding past experiences and the needs of the people we serve, including being

sensitive to any trauma they may have experienced. By offering support early and being thoughtful in how we provide care, we can help improve lives.

4.6.5 The focus of each priority remains the same, however the wording for Priority 1 has been changed to be more specific:

1. Enabling partners, including educational establishments, to use sound evidence and proven measures to target and support **children and young people** at risk of suicide.
2. Targeted support and resources at **higher risk groups and locations**, as identified by local and national data and evidence.
3. Improve our local understanding of **self-harm** and support people with a history of self-harm.
4. Providing effective **bereavement** support to those affected by suicide.
5. **Leadership** - Work with partners and communities to support their role within suicide prevention.

4.7 The action planning process has started. Five groups have been established, each covering one of the priorities, to devise evidence-based action plans.

4.8 The Suicide Prevention Strategy Steering Group has oversight of the action planning process, feeding into the Suicide Audit and Prevention Group.

4.9 Mitigations have been put in place to ensure the actions are ambitious, whilst remaining realistic, and don't solely fall on public health to deliver against. This includes a prioritisation matrix, allowing actions to be based on impact and resource, and a template with clear accountability.

Appendices
1 Consultation Survey

suicide prevention consultation results

2. Consultation Summary

The draft strategy consultation and ou

3. Strategy

DRAFT Suicide Prevention Strategy.