Suicide Prevention Programme – Monthly Clinic 6

10th February 2020, 10:00 – 11:00

Item	Summary	Resource
Introductions	**Suicide Prevention Programme Team Attendees** NCCMH: Emily Cannon, Helen Smith, Kaycee Meads, Saiqa Akhtar NCISH: Cathryn Rodway **Wave 2 sites** • Sussex • Staffordshire and Stoke on Trent • Cheshire and Merseyside **Wave 1 sites** • Lancashire and South Cumbria • Greater Manchester (GM) • Kent and Medway • Norfolk and Waveney • Coventry and Warwickshire **Trailblazer sites** • South West London • Buckinghamshire, Oxfordshire, Berkshire West • Devon • Derbyshire **Other Organisations** • Central and North West London NHS FT (CNWL) • Milton Keynes Council • Leicestershire Partnership NHS Trust • Blackburn and Darwen Borough Council	

	• Lincolnshire County Council	
Suicide prevention in in-patient settings	**NCISH – 10 Ways to Improve Safety** NCISH developed recommendations of ***10 ways to improve safety*** based on 20+ years of research. Cathy (NCISH) mentioned that one recommendation is 'safer wards'. Some examples of how to achieve a safer ward include: • Removing ligature points • Improving the in-patient environment such as having activities, recreation and access to Occupational Therapists; providing privacy and comfort; and making the environment more therapeutic. • Strengthening observation procedures. Cathy mentioned that when thinking about suicide prevention for in-patients, it's not just for patients that die on the ward. It also includes patients that die: • during discharge planning • towards the end of an admission • during agreed leave or having left with staff agreement • those that die after leaving the ward without staff agreement or with staff agreement but failed to return. For each of these, the risks and therefore recommendations for prevention are different. It was suggested to implement the following to reduce suicides: • Comprehensive care planning • Close community follow up while patients are on leave • Transition planning (e.g. to get patients ready for discharge). NCISH carried out a study on in-patient suicide under observation (2015). They found that a number of in-patient deaths occur when observations are carried out by staff who are less experienced or are not familiar with patients, or when staff are distracted by other events on the ward. It also looks at patients that leave without staff agreement or have staff agreement but haven't returned on time. It was commented that patients who abscond tend to have certain characteristics – more severe mental health problems, difficult life events such as homelessness.	NCISH 10 Ways to Improve Safety (JPEG) In-patient suicide under observation (2015) (PDF)

	Cathy shared that they have looked at Trusts before and after the implementation of at least one of the recommendations. These Trusts all saw a reduction in suicide rates after implementation. Greater Manchester (GM) mentioned that some areas are reliant on other parts of a whole system (e.g. the bed system). They asked how Trusts have managed to reduce suicide considering other factors that may affect them. Cathy mentioned that the Trusts would have implemented at least one recommendation but not all of them. ***Update:*** ***In NCISH's before- and after- analysis of implementation of mental health service recommendations study (While et al, 2012), they found that the Trusts that had implemented seven of nine recommendations had the greatest reductions in suicide rates.*** ***In a follow-up to this study, Kapur et al (2016) examined whether organisation factors (such as staff and patient satisfaction, staff turnover) might affect suicide rates and found that 'healthier organisations' had greater reductions in suicide rates when they implemented specific interventions.*** ***NCISH's Healthy service and safer patients report is associated with the above studies.*** NCISH shared the following documents: • NCISH Safer Services toolkit • NCISH Annual Report 2019 • NCISH STP Site Visit, Learning day and Annual Report 2019 slides • NCISH NSPA 2020 Slides If you have any questions for NCISH, you can contact: • Cathryn Rodway (Cathryn.A.Rodway@manchester.ac.uk) • Nicola Richards (nicola.richards-2@manchester.ac.uk)	Implementation of mental health service recommendations in England and Wales and suicide rates, 1997-2006 – While et al. 2012 (PDF) Mental health service changes, organisational factors, and patient suicide in England in 1997-2012 – Kapur et al. 2016 (PDF) Healthy services and safer patients – NCISH 2015 (PDF) NCISH Safer Services toolkit (PDF) NCISH Annual Report 2019: England, Northern Ireland, Scotland and Wales (website) NCISH STP Site Visit, Learning day and Annual Report 2019 slides (PDF)

	Central and North West London NHS FT (CNWL) – In-patient suicide prevention CNWL have a suicide and self-harm prevention strategy as well as a Zero Suicide strategy. They have been working on a ligature prevention strategy after a serious incident occurred 3 years ago. They run ligature point audits for all wards in the Trust. The audit team includes a clinician, a health and safety nurse manager and an estates manager. CNWL mentioned that people get anxious about what can be ligature points, but some cannot be moved or are not practical to move (e.g. smoke detectors). The estates manager helps to determine practical solutions. The audits are to keep consistency across all areas of the Trust – CNWL covers 5 London boroughs and includes a variety of ward types. It was mentioned that some areas of a ward are more high risk and it is important to be aware of what the environment looks like. They have implemented measures to address patients' failure to return from leave, based on Jill Bailey's work: • Providing a ward telephone number to help patients contact staff if they are returning late • Strengthening sign up procedures by including prompting questions (e.g. asking how you are and when you will return). CNWL mentioned that NCISH's 10 ways to improve safety are the backbone for their suicide prevention work. For example, they have created a package and competencies to improve staff's ability to do observations. Learning is shared in the Trust with clinical messages of the week and clinical risk assessments or memos. They also have weekly safety huddles to review incidents from the past week and discuss what they can do and how they can manage them better. CNWL mentioned they are looking to remove level 2 observations. They explained that it was because most incidents happen on level 2 observations and it gives people a false sense of security. The Trust mentioned that most suicides happen within intermittent observations.	NCISH NSPA 2020 Slides (PDF)

	If you have any questions about CNWL's work, you can contact Rebecca Deere (rebecca.deere@nhs.net). **Ligatures** Devon Partnership NHS Trust mentioned that many suicides, usually by ligature, don't necessarily have an anchor point and that people with a personality disorder diagnosis can ligature quite often. They asked if anyone had any ideas of how to address this. Oxford mentioned they have seen a big increase in self-harm. They are holding an event in March on self-harm on non-suspended ligatures. The focus is on the impact to staff. They have someone from an adolescent ward speaking at the event as well as people who have done improvement work around this. This event is targeted to frontline staff. It was asked if Oxford can share information on what certain Trusts are doing from the conference.	
AOB	The final monthly clinic is on the **9th March 2020**. The deadline to book a slot on the clinic is the **28th February 2020**.	

Contacts

Contact person	**Email address**
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Resources

Resource	**Link**
NCISH 10 Ways to Improve Safety	https://www.rcpsych.ac.uk/docs/default-source/improving-care/nccmh/suicide-prevention/wave-1-resources/ncish-10-recommendations-graphic.jpg
In-patient suicide under observation (2015)	https://www.rcpsych.ac.uk/docs/default-source/improving-care/nccmh/suicide-prevention/monthly-clinic/in-patient-suicide-under-observation-(2015).pdf

Implementation of mental health service recommendations in England and Wales and suicide rates, 1997-2006: a cross-sectional and before-and-after observational study (While et al. 2012)	https://www.rcpsych.ac.uk/docs/default-source/improving-care/nccmh/suicide-prevention/monthly-clinic/implementation-of-mh-service-recommendations-while-et-al-2012.pdf
Mental health service changes, organisational factors, and patient suicide in England in 1997-2012: a before-and-after study (Kapur et al. 2016)	https://www.rcpsych.ac.uk/docs/default-source/improving-care/nccmh/suicide-prevention/monthly-clinic/mental-health-service-changes-kapur-et-al-2016.pdf
Healthy services and safer patients: links between patient suicide and features of mental health care providers – NCISH (2015)	https://www.rcpsych.ac.uk/docs/default-source/improving-care/nccmh/suicide-prevention/monthly-clinic/healthy-services-and-safer-patients.pdf
NCISH Safer Services toolkit	https://www.rcpsych.ac.uk/docs/default-source/improving-care/nccmh/suicide-prevention/monthly-clinic/safer-services_a-toolkit-for-specialist-mental-health-services.pdf
NCISH Annual Report 2019: England, Northern Ireland, Scotland and Wales	https://sites.manchester.ac.uk/ncish/reports/annual-report-2019-england-northern-ireland-scotland-and-wales/
NCISH STP Site Visit, Learning day and Annual Report 2019 slides	https://www.rcpsych.ac.uk/docs/default-source/improving-care/nccmh/suicide-prevention/monthly-clinic/ncish-stp-site-visit-learning-day-and-annual-report-2019-slides.pdf
NCISH NSPA 2020 Slides	https://www.rcpsych.ac.uk/docs/default-source/improving-care/nccmh/suicide-prevention/monthly-clinic/ncish-nspa-2020-slides.pdf