Suicide Prevention Programme – Wave 3 Workshop 3

9th March 2021, 13:00 – 14:00

Details	Link
Welcome and introduction Tom Ayers, NCCMH The aim of these workshops is to bring a learning community together to support each other, discuss issues and share some of our work around suicide prevention.	Please get in touch with NCCMH at Suicide.Prevention@rcpsych.ac.uk if you would like to contact any workshop participants.
Item 1: **Prevalence of suicide in people who are receiving treatment from mental health services** Anthony Reilly, Clinical Lead, Safe from Suicide Devon Partnership NHS Trust With the new burden of proof criteria, it would be helpful to understand how others approach benchmarking when reviewing potential suicides within a Trust? For example, through real-time surveillance (RTS) we may question when a drugs overdose is suicide or misadventure. Are there any Trusts who are involved in doing this in a real time surveillance fashion – i.e. picking up specific cases to review - or are some waiting until the case has gone through the full coroner's process and getting that result before reviewing from a suicide perspective.	• For information on burden of proof: Suicides in England and Wales - Office for National Statistics (ons.gov.uk)
Discussion: **Essex County Council's** team is looking at setting up RTS and are having conversations around how they look at comparable data sets to include police suspected suicide data as well as the coroner's data.	

Gloucestershire County Council undertake RTS of suspected suicides and have a steering group which includes very good representation from the coroner, police and mental health trust. They meet weekly to discuss the events leading up to a death when it involves suspected suicide. Having that good relationship means there is a lot of discussion generated. Police and coroner provide updates – determining whether they feel it was a suspected suicide using the evidence available and any contributing/influencing factors.
In terms of burden of proof, the team continue to use best interpretation of the evidence that is available, and this seems to be consistently in line with coroner's conclusion.

There are challenges around the amount of data being collected, monitored, and discussed, in case the coroner concludes a death was not suicide.

Gloucestershire Health and Care NHS FT have identified a need to determine at what point a person who has been in contact with a service can be defined as a patient. For people who have limited contact with primary care or IAPT services this can be challenging. Additionally some people who have no defined mental illness but do have a history of multiple contacts with the Crisis team may not be on a caseload – so people in this group would be reviewed on a case-by-case basis.

Hertfordshire Partnership University MHS FT review on a case-by-case basis – and when reviewing people who have had limited contact with services, learning taken from that intervention are considered retrospectively. The team has also trialled requesting a brief summary of contacts/medication etc from GPs for suspected suicides in Hertfordshire to inform Serious Incident reviews, for the purposes of lessons learned and suicide prevention. GPs have engaged well and have provided a wide range of information that has been helpful. GPs are also invited to reflective learning sessions.

Rotherham, Doncaster and South Humber NHS FT report every death of someone they've had contact with in the last 6 months on their mortality system and review as to whether it needs to be a Serious Incident, a Structured Judgement review or closed. While the review is on a case-by-case basis, if it is a suspected suicide it is more likely to be a Serious Incident or a Structured Judgement review. This review also supports the learning.

Nic Richards from NCISH advised that with the burden of proof changes we are likely to see an increase in suicides being confirmed. However it is of note that as we started to see an

increase in suicides before the change was confirmed, it cannot be wholly attributed to the burden of proof changes. **Somerset Public Health** have been collecting data from the coroner since 2015 and have found that about 20-30% of cases of suspected suicides are determined not to be suicides. The team also suggest that when undertaking suicide case review meetings it could be useful to record all contacts with MH teams, to identify which service had seen them and when (e.g. Home Treatment team, Community MH team etc). This can be cross referenced with other services (e.g. drug and alcohol/domestic violence/Adult and Children's Social Care) – as often there are cases who are known more than one of those services. There is a new Community MH service in Somerset called Open Mental Health and there are discussions ongoing as to whether Community MH services should be treated in the same way as a GP/Primary care type service in terms of the protocols/types of reviews it undertakes versus being part of the MH service, for example in Serious Case reviews. **Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust** also try to focus on preventable deaths as this helps confirm the purpose of what we are doing rather than being caught up with the detail. **The Hope Project in Bristol** are launching a support after suicide service in mid-May, in Bristol, North Somerset and South Gloucestershire which will involve working closely with the coroner's office.	
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Item 2: **Resilience therapy within a self-harm pathway** Vicki Wagstaff, Clinical Network Manager – Mental Health Healthier Lancashire & South Cumbria Mental Health Team **Lancashire & South Cumbria** are pulling together a NICE guidance-led self-harm pathway. There is a lot of information relating to resilience training/building, but the term **resilience**	

therapy is also being used. Are others in the group familiar with resilience therapy and/or incorporated this into their care pathways?	
Discussion: It was noted that there are some questions around the use of the word 'resilience'. In addition, rather than people struggling to improve resilience on their own, there is an opportunity for networks/organisations to further support individuals. **North Cumbria** are undergoing Connecting with People training – this includes **emotional resilience training** which is around helping people to develop safety planning and how to access the support that is available. **East of England NHSE** – a service provider in Norfolk and Suffolk is piloting an approach which combines a traditional NICE concordant psychotherapy offer with a 'socio-mobilisation' offering – includes supporting skills to manage behaviour, to engage with community networks better, and to live more safely – with or without self-harm. Resilience has come up a lot in these conversations.	
Details	**Link**
Item 3: **Ligature Risk Assessments** Anne Prendergast, Lead for Clinical Risk and Suicide Prevention Coventry and Warwickshire Partnership Trust 1. For those of us providing inpatient services we already do a yearly assessment, but the challenge is that patients are finding new items/ligature points. We are considering including **service users by experience** when writing ligature risk assessments. If others have tried this approach were there any benefits or challenges to be shared?	

2. The CQC have recently changed their guidance for inspectors for ligature risk assessments for bedrooms, bathrooms and toilets where all ligature risks (no matter how high up they are located) are considered a high risk. Has anyone any tips/ideas to share within this context?	
Discussion: **Herts Partnership University NHS FT** undertook a Serious Incident Review for a near-miss ligature incident and as part of the review, met with the service user. Including service users by experience and having that insight could be beneficial as by having the conversation, the team can be made aware of issues not previously considered. The concept of including an expert by experience when undertaking ligature risk assessments on the wards has been taken to the Trust Safety Committee for consideration. **Devon Partnership** have no formal process in place but have had experience of service users providing insight into risks on leaving the ward. This team have moved away from the Manchester tool when carrying out the risk assessment and are now looking at every category – regardless of height what is the risk associated with any height; how private is the room; how often do staff go into the room/high visibility etc and formulate a clear mitigation plan against all those risks. It was felt that focussing only on fixed point assessments was not enough – in this area over half of ligature incidents did not involve a fixed point. Having service user involvement will help identify and understand what patients can use/find in the environment. **Oxford Health NHS Foundation Trust's** Director of Nursing forum are developing guidance around ligatures. There is also some regional work taking place to develop a community of practice around working with ligatures in order to share experiences and ideas, In addition, Oxford Health are collaborating with University of Oxford Centre for Suicide Research, undertaking a research	

project which involves a national survey of inpatient staff, on the experiences and impact of working with ligatures; with the aim of quality improvement work going forwards. If available, NCCMH will share any resources at a later date. **NCISH** – When thinking about safer wards in general – including ligature points – staff observing patients is very important. NCISH will look at whether there is anything standardised in terms of training and will share if available.	