South Staffordshire and Shropshire Healthcare NHS
NHS Foundation Trust

Learning Lessons Quarterly Bulletin

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Focus on Reducing Deaths From Self Harm

Welcome to South Staffordshire and Shropshire Healthcare NHS Foundation Trust's Learning Lessons bulletin.

As a Trust we recognise the benefits that can be had from sharing and cascading learning from incidents and near misses, and know that if this is done effectively it can help to minimise future risk and strengthen the quality of the services we provide.

The Trust is committed to quality improvement, and will continue its strong focus on delivering high quality, safe and effective services. This new quarterly bulletin is an important component of a number of key approaches embraced by the Trust to drive forward the quality agenda.

The ultimate aim of evaluating our services and learning lessons is to improve outcomes for service users. This bulletin is intended to support this aim by communicating and strengthening local and national lessons to be learnt from both positive practice and areas for improvement.

In this issue we have focused on reducing deaths from self harm which remain a high risk for services.

We hope that you find this bulletin informative and useful and welcome your ideas and input into future issues.

OFFICE FOR NATIONAL STATISTICS—Suicides in the United Kingdom, 2011

In January 2013 The Office for National Statistics released the following data on suicides in the UK:

- In 2011 there were 6,045 suicides in people aged 15 and over in the UK, an increase of 437 compared with 2010.
- The UK suicide rate increased significantly between 2010 and 2011, from 11.1 to 11.8 deaths per 100,000 population.
- There were 4,552 male suicides in 2011 (a rate of 18.2 suicides per 100,000 population) and 1,493 female suicides (5.6 per 100,000 population).
- The highest suicide rate was in males aged 30 to 44 (23.5 deaths per 100,000 population in 2011).
- The suicide rate in males aged 45 to 59 increased significantly between 2007 and 2011 (22.2 deaths per 100,000 population in 2011).
- Female suicide rates were highest in 45 to 59-year-olds in 2011 (7.3 deaths per 100,000 population).

Learning Lessons Features

The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness

In July 2012 the National Confidential Inquiry produced its annual report based on data collected January 2000 to December 2010. the full report can be found at:
http://www.bbmh.manchester.ac.uk/cmhr/centreforsuicideprevention/nci/reports/annual_report_2012.pdf

Key Findings:

- ◊ In patient suicides show a sustained fall across all countries
- ◊ There was a substantial fall in in-patient suicides following absconding in England. Numbers were too small for analysis in other countries.
- ◊ Deaths under crisis resolution/home treatment are now more frequent than under in-patient care in England and Wale
- ◊ In England and Wales there has been a fall in the number of patient suicides following refusal of treatment or care.
- ◊ There are few suicides by patients refusing treatment or care while under a community treatment order (England and Wales).
- ◊ There has been a decrease in the number of patient suicides by overdose of tricyclic antidepressants in England, Scotland and Wales.
- ◊ Figures for alcohol misuse/dependence among suicides and homicides are higher in Scotland and Northern Ireland. Drug dependence is higher in Scotland.
- ◊ Suicides in Northern Ireland continue to increase in contrast to England, Wales and Scotland.
- ◊ The number of patient homicides in England has fallen since a peak in 2006.

"The incident details are uploaded to outside agencies such as the NPSA and CQC. That's why there should be no person identifiable information".

Key Messages for services:

- ◊ There have been improvements in patient safety across all countries, especially in-patients. Services should maintain these successful measures.
- ◊ Safer prescribing of psychotropic drugs remains an important aspect of suicide prevention.
- ◊ Services should now focus on safety in crisis resolution/home treatment. More evidence is needed on deaths of patients under these services.
- ◊ Safety in mental health services could be improved by addressing co-morbid use of alcohol, especially in Scotland and Northern Ireland.

Risk Management Team

Learning Lessons Features

Standards for Carer Engagement

One of the recurrent themes from investigations in to self harm deaths has been that we have not engaged effectively with carers. Carers are the people who have the closest most frequent contact with service users. They are often the first people to identify early warning signs of risk and they are the people who are hurt the most when there is a self harm death. For this reason, as an organisation we have adopted a number of standards for engaging with carers.

Standard 1 *Involvement*	**Standard 2** *Engagement*	**Standard 3** *Information Sharing*	**Standard 4** *Provision of Information*	**Standard 5** *Support*
Identification of a carer should be a routine part of a service users assessment	All clinical staff should receive carer awareness training	Service user consent should be sought to share information and the level of information which can be shared as a routine part of assessment and re-visited regularly	Carers should be provided with information about the service on first contact or as soon after as is possible	The Trust has a carer support service in place
Carers views and knowledge should be routinely sought throughout assessment, care planning, intervention and review	Clinical supervision should address carer engagement and awareness		Information should explain the service and points of contact	Carers should have access to local advocacy services and be offered information about carer support organisations and groups/community directories
Where there are consent issues regarding carer involvement this should be routinely re-visited	The Trust should identify staff who are carer champions and who support staff and input into awareness training	Carers should be offered support and general information even when consent has not been agreed with the service user	Carers are offered an early formal appointment to hear their story and address any carer concerns	
The carer should be routinely updated and involved in planning and review / discharge meetings		Carers should be encouraged to share information regarding the service user as this will inform assessment, planning, intervention and review/discharge	Carers should be offered information regarding therapeutic interventions, diagnosis and medication monitoring	Carers should have access to 1:1 support when needed
Treatment and strategies for medication management should be explained to carers	A Carer Engagement Forum is in place to consider ongoing awareness and engagement issues		A Trust information pack should routinely be provided to carers as part of the introductory process	Carers are offered a carers assessment and, where appropriate, a support package
Carers should have access to advice re advocacy, equipment and welfare rights		Advance statements or directives should be routinely discussed with service users and discussed with carers where appropriate	The format of information provided by the Trust is flexible and regularly updated Carers should be made aware of the PALS and complaints process	Family therapy or talking therapies are offered to carers if required

Best Practice Tips From Serious Incident Investigations

The Trust promotes an open incident and near miss reporting culture and recognises that to learn from incidents and prevent reoccurrences, it is important that lessons are shared. Each edition of the Trust's Learning Lessons Bulletin will include a series of best practice tips that have been identified through the Trust's investigation into recent serious incidents.

The best practice tips not only focus on areas identified for improvement but also incorporate elements of positive practice that have been highlighted as part of the investigation process.

⚠ **We must** engage carers—they are key in helping to keep our patients safe

⚠ For every risk identified there must be a management plan.

⚠ It is important to co-work service users with dual diagnosis. Substance misuse is a significant risk factor in suicide and homicide and is not a diagnosis of exclusion.

⚠ Physical ill health is a significant risk factor. It is important to recognize the impact of changing physical health needs including pain management, in the risk management plan.

⚠ Remember that the risk management plan is only as good as the time and effort put into sharing its findings with other (DH 2007 Best Practice in Managing Risk)

Learning Lessons—High Risk Indicators for Serious Self-Harm

In order to support staff assessing and managing suicidality there are "Guidelines for the Management of Serious Self Harm and Suicidality" .

Assessment of risk of suicidality or self harm is a dynamic process which should include assessment of:

- Suicidal intent and lethality
- Changing meanings and motivations for suicide
- Presence of a suicide plan
- Presence of overt suicidal/self harming behaviour
- Service user's physiological, cognitive and affective states
- Service user's coping potential
- Service user's epidemiological risk factors
- Environmental risk factors
- Situational risk factors
- Feedback from other professionals
- How often patient has been referred to a service

Further information can be found as an annex to the Clinical Risk Management Policy at http://www.southstaffsandshropshealthcareft.nhs.uk/getattachment/f4110390-8b98-4773-a1b8-4801dc2e0763/C-YEL-gen-i-(1).aspx.

National Resources

Patient Safety First is a national campaign and is sponsored by the National Patient Safety Agency and the NHS Institute for Innovation & Improvement. The campaign aims to make safety of patients everyone's highest priority with no unavoidable deaths and no unavoidable harm . The Campaign website contains a range of simple, yet effective ideas for improving patient safety within organisations. The link to the Patient Safety First Campaign website is: http://www.patientsafetyfirst.nhs.uk

Central Alerting System

The Central Alerting System (CAS) is a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and others, including independent providers of health and social care. Risk management distribute relevant alerts to directorate risk co-ordinators for cascading. Further information about alerts can be found at: https://www.cas.dh.gov.uk/Home.aspx

On 10th December 2012 the Department of Health issued "Preventing Suicide– A Cross-Government Outcomes Strategy to Save Lives. The strategy is intended to provide an approach to suicide prevention that recognises the contributions that can be made across all sectors of our society. It draws on local experience, research evidence and the expertise of the National Suicide Prevention Strategy Advisory Group, some of whom have experienced the tragedy of a suicide within their families. The strategy identifies measures to support families – those who are worried that a loved one is at risk and those who are having to cope with the aftermath of a suicide. The strategy also makes more explicit reference to the importance of primary care in preventing suicide and to the need for preventive steps for each age group.
Further information can be found at the following link: http://www.dh.gov.uk/health/files/2012/09/Preventing-Suicide-in-England-A-cross-government-outcomes-strategy-to-save-lives.pdf

This guideline is concerned with the longer-term psychological treatment and management of both single and recurrent episodes of self-harm, and does not include recommendations for the physical treatment of self-harm or for psychosocial management in emergency departments (these can be found in NICE clinical guideline 16).
Further details about this guidance can be seen at the following link: http://www.nice.org.uk/nicemedia/live/13619/57179/57179.pdf

In July 2012 the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness released its 2012 report. The report covers deaths by suicide for the period January 2000 to December 2010, people convicted of homicide (homicide convictions) between January 2000 and December 2010 and sudden unexplained deaths (SUD) in psychiatric in-patients for this period. . The link to the report on the University of Manchester website is: http://www.medicine.manchester.ac.uk/cmhr centreforsuicideprevention/nci/reports/annual_report_2012.pdf

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This Bulletin is available on the Trust website at :

http:// www.southstaffsandshropshealthcareft.nhs.uk/Default.aspx

Or alternatively

A hard copy can be obtained by contacting the Trust Risk Management Department on 07850 257888 ext 5953

- We welcome your feedback on this Learning Lessons Bulletin to help us to ensure that future editions are helpful and informative

- We would also welcome your ideas for future features or areas of learning you feel are relevant to be cascaded across the Trust

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