Positively Different

South Staffordshire and Shropshire Healthcare NHS
NHS Foundation Trust

Learning Lessons Quarterly Bulletin

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Focus on Suicide of Community Mental Health Patients

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 our leaning from the recent review of suicides in community mental health service users.

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

Statistics on Suicides of Community Mental Health Patients

- In 2013/14 South Staffordshire and Shropshire Healthcare NHS Foundation Trust had 50 reported suicides by existing or discharged community patients.
- The National Service Framework for Mental Health(NSF) target was 7.3 per 100 000 population, the figure for the South Staffordshire and Shropshire geographical area in 2013/14 was 7.41per 100 000 population which is in line with the NSF target and a fall of 10 per 100 000 since 2012/13. (Please note this figure does not include services provided outside South Staffordshire and Shropshire as the population could not be calculated).
- The mean number of community suicides for the organisation as a whole, was 4 per month for 2013/14. This is a slight increase from the previous figure of 3.17 for 2012/13.
- There has been an increase in suicides in the age group 45-64 years.
- In 60% of the suicides, carers had not been engaged.

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

Learning Lessons Features

National Confidential Inquiry

In July 2014 the National Confidential Inquiry into Suicide and Homicide by people with mental illness published its findings for 2012-13. This page summarises the findings relating to community suicides in that review;

Key Findings:

◊ **Discharge from inpatient services:** 18% of suicides occurred within a week of being discharged and before a follow up visit had been made

◊ **Crisis Resolution/Home Treatment:** 11% of suicides occurred when under the care of Crisis Resolution /Home Treatment. 47% of these service users lived alone, 49% had recently experienced adverse life events and 34% died within 3 months of discharge from inpatient care.

◊ **Missed contact:** on average 26% of patients missed their final service contact.

◊ **Use of substances:** 54% of patient suicides had a history of either alcohol or substance misuse or both. 15% of patient suicides had severe mental illness and co-morbid alcohol or drug dependence/misuse.

◊ **Schizophrenia:** 18% of patient suicides had a diagnosis of "schizophrenia". The National Confidential Inquiry is predicting a rise in this figure over the next few years in line with the increase in patients overall. Of those diagnosed with Schizophrenia 23% refused drug treatment in the month before death.

National Recommendations from the 2014 Review:

1. **Patient suicides**
   - Address economic pressures facing patients (working with relevant agencies)

2. **Suicide after discharge**
   - Effective care planning, addressing life events
   - Early follow-up
   - Caution over short admissions
   - Suicide <3 days a 'never event'

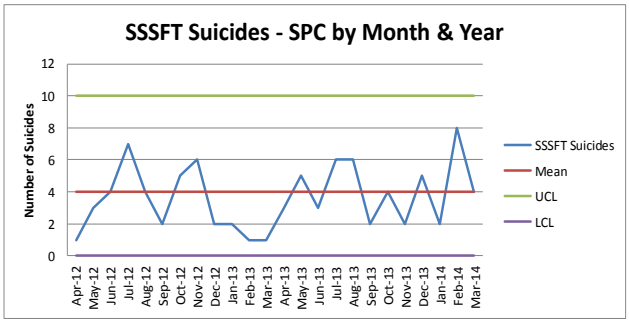
3. **Suicide under CR/HT**
   - Priority for suicide prevention
   - Review suitability for certain patients

4. **Suicide by hanging**
   - Media portrayals to be re-examined

Learning Lessons Features

Community Suicides

This page outlines the findings of the review into suicides by community mental health patients in 2013-14 for South Staffordshire and Shropshire Healthcare NHS Foundation Trust.



This chart shows that, as an organisation there are between 1 and 8 suicides reported each month by service users of this Trust.

Key Risk Factors

An in depth review of each of the cases identified the following risk factors relating to suicide. These factors should be considered when assessing for risk of potential suicide.

Demographics:
Historically young people aged between 15 and 25 are high risk and this fact remains however more recent research both locally and nationally has shown an significant increase in the 45-60 age group which is being attributed to the recession. In addition there has been an increase in suicide in the over 65 population.

Teams:
The last year has seen a fall in the rate of suicides for Community Mental Health Teams but an increase in suicides in Crisis Resolution/Home Treatment (CRHT). This change is attributed to the change in roles of the teams impacting on the numbers of acutely ill patients being the responsibility of CRHT at any one time. The high numbers of service users within substance misuse services is described under "Use of substances".

Carer involvement:
The engagement of carers is an essential element of the risk management process. The carer will be able to identify and respond to any "early warning" signs of increasing risk and will often be key in avoiding admission. Although there had been an improvement from 2012/1 there was still only evidence that carers were engaged in 40% of the cases of suicide for this year.

Disengagement:
In 30% of the cases the service user had not attended the appointment immediately prior to the suicide. This risk factor is also reflected in the national statistics. These figures emphasise the need for clinicians to review the risk of service users who DNA appointments and respond accordingly bearing in mind this is a known risk indicator.

Relationship difficulties/Bereavement:
In 24% (one quarter) of service users who committed suicide relationship difficulties (including bereavement) were identified as factors contributing to the incident. It is important for staff assessing risk to recognise this as a high risk factor when carrying out their assessment particularly over 65 year olds who have experienced bereavement in the last 12 months.

Use of substances:
60% of the suicides in 2013/14 showed a history of misusing substances compared to 34% in 2012/13. Staff need to include use of substances in their formulation of risk and bear in mind that use of substances is not a diagnosis of exclusion.

Deteriorating physical health:
Although overall only 15 of cases recorded "deteriorating physical health" as a contributory factor, it was identified as a contributory factor in over 80% of those over 65 years of age. Where necessary staff need to respond to changes in physical health needs by signposting and reviewing the risk level. This also correlates with DNA levels.

Hopelessness:
The reviewer found that "suicidal ideation" and "presence of a plan" were given more weighting in risk assessment than "expressions of hopelessness". The evidence in both research and through this review that of the 80% of cases who denied current ideation 55% had stated expressions of hopelessness in the month prior to the suicide. Staff advised to address "hopelessness" as a priority in their intervention plan.

Sarah Hankey
Risk and Claims Manager

Agreed Recommendations from the Review of Suicides in the Community

The Trust has agreed with the findings of the review and is supporting the implementation of the following recommendations as a result:

- Ensure the key risk factors feature in the clinical assessment of suicidality including:
  - Relationship difficulties, chronic depression and deteriorating physical health
  - Presence of "hopelessness" as an indicator
  - Effectiveness of an identified plan as a tool for assessment of suicidality.
- Continue to monitor methods of suicide to identify any early clusters or trends.
- Continue to monitor suicides by team suicide to identify any early clusters or trends.
- Ensure the requirement to engage with carers continues to be shared through existing processes.
- Develop programme plan for the implementation FACE (Risk Assessment Tool on Rio) - From July we will be training staff on the effective use of FACE to inform robust risk management planning

Useful Resources:

"Helping you stay safe" - http://www.connectingwithpeople.org/sites/default/files/

"U can cope" http://www.connectingwithpeople.org/ucancope

"Feeling on the Edge? Helping you get through it" -
http://www.connectingwithpeople.org/sites/default/files/Feeling%20on%20the%

"Preventing Suicide: A Toolkit for Community Mental Health" -
http://www.nhsconfed.org/~/media/Confederation/Files/public%20access/Preventing-suicide-toolkit-for-community-mental-health.pdf

"Survivors of Bereavement by Suicide" http://uk-sobs.org.uk/

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

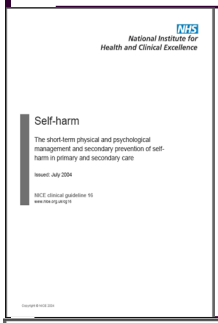
The Central Alerting System (CAS) is a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and others, including independent providers of health and social care. Risk management distribute relevant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

Preventing suicide in England
A cross-government outcomes strategy to save lives

HM Government

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 2014 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 2002 to December 2012, people convicted of homicide (homicide convictions) between January 2000 and December 2012 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.bbmh.manchester.ac.uk/cmhs/centreforsuicideprevention/nci/reports/Annualreport2014.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 0300 790 7000 ext 8695

- 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

For all enquiries and comments please Contact:

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