Suicide Strategy 2014/2015
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1. Introduction

Quality Definition:

“The users of our services are the first priority in everything we do, ensuring that they receive effective care from caring, compassionate, and committed people, working within a common culture and protected from harm.”

The 5 Boroughs Partnership NHS Foundation Trust is committed to preventing suicide. To illustrate this commitment to change, the development of this Suicide Strategy was set as a corporate high level objective under ‘Service delivery and patient experience’ strategic theme for 2012/13. It is owned by the Director of Nursing and Quality and sponsored by the Medical Director. This is a bespoke 5 Boroughs Partnership NHS Foundation Trust Suicide Prevention Strategy.

This Strategy is based on the findings of a clinical audit conducted within the Trust. In addition national and international policy, guidance documents and current research on suicide and suicide prevention have been taken into consideration. The methodology of the audit and findings are in appendix 1 and the bibliography is in appendix 2.

This Strategy sets out the measures that the Trust will implement to reduce suicide locally.

Suicide is a complex behaviour with a number of underlying causes therefore approaches to prevention must be wide-ranging. The key elements of this Strategy that will enable us to do this are:

- Continue to develop close partnership-working between clinical services and Integrated Governance
- Post incident review of serious incidents
- Strengthened governance on communication and record keeping
- Clear acceptance/discharge criteria for individual teams
- Review & monitor levels of self-harm across the Trust
- Implementation of a trust wide suicide training Programme
- To initiate an on-going Suicide Prevention Group that will work closely with the self-harm working group.

2. The Goal

To reduce the number of suicides in the Trust to zero

Managing a system of care to achieve that goal is courageous but we believe we must aspire to this. It will require the Trust to evaluate performance rigorously and to use serious incidents as opportunities to improve our capacity to save lives at risk.

Positive health and behavioural health outcomes are partly dependant on a functional relationship between the patient requiring help and the staff delivering help. Such alliances are most productive when the care is
collaborative; where the patient is actively engaged in making choices that will keep him/her safe.

The Trust will aim to ensure that by working in partnership with other agencies, vulnerable people in the care of mental health and social care at risk of suicide are supported and kept safe from preventable harm. We can also ensure that we intervene quickly when someone is in distress or in crisis.

2. Actions and Implementation

In order to achieve the goal, five key objectives have been identified:-

Objective 1:

The formation of a dedicated Trust body, The Suicide Prevention Oversight Committee

The Suicide Oversight Committee will drive the implementation of this strategy forward and close an annual audit cycle. It will be the crucial link to the high level Executive Leadership necessary to drive the major cultural changes and training necessary to make this Strategy successful.

Objective 2:

To embed in practice the use of a dedicated Suicide Assessment Scale

Suicide assessment should be done as part of a separate, dedicated process distinct from generic risk assessment. There is no substitute for comprehensive clinical examination and interview; however it should be supported by a bespoke suicide assessment tool such as the Columbia Suicide Rating Scale. This tool has been validated both in clinical and research practice nationally and internationally. It is free, quick and easy to complete with free on line training and certification are available. It is already in use in the Trust Clinical Trials Unit

Objective 3:

Embed in practice the use of a Suicide Intent Scale for Patients identified at being a risk of suicide by the Suicide Assessment Scale

Individuals identified as being at high risk of suicide should have a focused intervention in the form of a Suicide Intent Scale 25-point questionnaire. In addition to targeting factors involved in self-harm and suicide attempts it would have the additional advantage of building a critical close therapeutic and trusting relationship between clinicians and service users as well as providing training in practice on the assessment of this high risk area.
Objective 4:
Focus on assessment, management and training for self-harm and substance misuse

The audit mirrored the national position in showing that those people who self-harm and attempt suicide are massively overrepresented in the suicide population. It also showed that substance misuse was a high risk factor. We would recommend dedicated training on the assessment, treatment and general management of these two high risk groups. Close working between the suicide and self-harm working groups would support this and help make the necessary cultural changes to staff attitudes to benefit these subjects.

Objective 5:

Initiate and implement a multi-disciplinary clinical review for all service users who disengage from services or repeatedly do not attend appointments.

Evidence from audit data and serious incidents indicates that service users who disengage from services or do not attend initial or follow up assessments may be at increased risk of suicide. The nature of the clinical review will be agreed, implemented and acted upon.
Appendix 1

Design of project

The Associate Medical Director for Education and Research was asked to develop and deliver a suicide audit to identify specific issues related to suicide within 5 Boroughs Partnership NHS Foundation Trust. A dedicated team of senior clinicians was assembled and organised into a pyramid system with a rating group reporting to a senior raters group that also included members of the Audit Department. This second group conducted a systematic literature search on Suicide and Suicide prevention supported by the Library. This identified a number of documents with The National Confidential Inquiry into Suicide and Homicide Report underpinning much of the design of the bespoke questionnaire although there was greater focus on qualitative as well as a quantitative data. The audit tool then went for further approval and amendment to the Clinical Leadership Group and the Associate Medical Directors, Forum. These groups maintained oversight of the audit data as it was collected so as to respond to findings in a formative way rather than summative. In addition there was service user input to the Senior Raters group and a number of service users kindly shared their experience of suicide attempts and ideation in interview with the audit lead. The audit tool was piloted and refined as the audit was undertaken. The study sample was obtained from the risk department within the trust. Data was collected from serious incident reviews and associated medical records for a period from January 2007 through to December 2012. All subjects had undergone an Inquest and a definition of suicide was adopted of a Coroners finding of “suicide or open verdict” as per The National Confidential Inquiry. The audit involved the forensic retrospective examination by raters of all documentation during the period in question. Additional Trust specific data was also obtained on request from The National Confidential Inquiry team based at the University of Manchester. The half way data was presented to the Joint Academic Forum and the Quality Committee for comment and the final raw data was presented to the Clinical Leadership Group and Joint Academic forum.

The final results, in conjunction with various national and international research, prevention policies, audits and individual comments was then used as the basis of the Suicide Prevention strategy.

Qualitative Findings

The findings of the audit highlighted a number of areas, both qualitative and quantitative which we need to focus on in terms of delivering improvement.

Qualitative:

- Communication
- Record-keeping
- Risk-management.
Financial difficulties

Quantitative findings were:

- Particular risk factors, as with the national picture, were those subjects who either attempted suicide before (circa 2/3) or who had a history of self-harm (circa ½).

- The audit found low rates of death by overdose (circa 1/9) but rates of hanging and strangulation matched the national picture, particularly in men.

- Depression (circa ¾) was found to be the most common diagnosis in keeping with the National Confidential Inquiry.

- Male sex (circa ¾)

- Three patients (3%) died in hospital compared to 97% who died in community settings.
Appendix 2

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