Kent and Medway
NHS and Social Care Partnership Trust

# Suicide Prevention Strategy 2016-2019

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## REFERENCES


White Paper - Saving Lives, Our Healthier Nation (1999)
The National Suicide Prevention Strategy (Department of Health 2002)
Avoidable Deaths: Five Year Report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. The National Confidential Inquiry 2006
Best Practice in the Assessment and Management of Risk to Self and Others in Mental Health Services (Department of Health 2007)
Suicide Prevention Tool Kit for inpatient services (National Patient Safety Agency 2009)
Depression in Adults: Recognition and Management. (National Institute for Health and Care Excellence (NICE) (Clinical guideline CG90 December 2009)
Strategies to Reduce Missing Patients: A practical work book (National Mental Health Development Unit 2009)
Sign up to Safety, NHS England, NHS Quality Account Regulations (Department of Health 2010)
No health without mental health: a cross-government mental health outcomes strategy for people of all ages (Department of Health 2011)
Suicide prevention toolkit for primary and secondary care services (National Patient Safety Agency 2011)
Clinical Guideline 133 Self Harm: Longer Term Management (NICE November 2011)
Public Health Outcomes Framework for England 2013-2016 (Public Health England Department of Health January 2012)
NHS Quality Accounts Toolkit (Department of Health 2012)
Preventing suicide in England: a cross-government outcomes strategy to save lives, (Department of Health September 2012)
Prompts for local leaders on suicide prevention (Department of Health September 2012)
Annual Report of the Chief Medical Officer 2013, Public Health Priorities (2013)
Self Harm (NICE) (NICE Quality standard QS34 June 2013)
Preventing Suicide in England: One year on, first annual report of the cross-government

outcomes strategy to save lives (Department of Health January 2014)
Preventing Suicide: A global imperative (World Health Organisation 2014)
Guidance for developing a local suicide prevention action plan (Public Health England September 2014)
Preventing Suicide in England: Two years on (Department of Health February 2015)
National Confidential Inquiry into Suicide and Homicide by people with Mental Illness Annual Report, The National Confidential Inquiry (July 2015 and previous annual reports)
Kent and Medway Multi-Agency Suicide Prevention Strategy 2015-2020
ICD-10 and DSM-IV diagnostic classifications.

## RELATED POLICIES/PROCEDURES/protocols/forms/leaflets

| | |
|---|---|
| Crisis Care Concordat, HM Government 2014 | |
| Quality Account, Patient Safety, Patient Experience and Clinical Effectiveness 2011-12., (KMPT) | |
| Care Pathway and CPA Policy | KMPT.CliG.001 |
| DNA Policy | KMPT.CliG.014 |
| Clinical Risk Assessment and Management of Service Users Policy | KMPT.CliG.009 |
| Supervision Policy | KMPT.CliG.045 |
| Overarching Information Sharing Policy | KMPT.InfG.065 |
| Safeguarding Vulnerable Adults | KMPT.CliG.06 |
| Health and Social Care Records Policy | KMPT.CliG.071 |
| Has someone you know been bereaved by suicide? Trust leaflet | 2012 |

## ABBREVIATIONS

| | |
|---|---|
| **ASIST** | **Applied Suicide Intervention Skills Training** |
| **AWOL** | **Absent without leave** |
| **CPA** | **Care Programme Approach** |
| **KMPT** | **Kent and Medway NHS and Social Care Partnership Trust** |
| **NCISH** | **National Confidential Inquiry into Suicide and Homicide by people with mental illness** |
| **NICE** | **National Institute for Health and Social Care Excellence** |
| **SI** | **Serious Incident** |
| **SPA** | **Single Point of Access** |
| **STORM** | **Skills Training On Risk Management** |

**CONTENTS**

## 1 INTRODUCTION

1.1 Putting an end to suffering and restoring health and occupational and social functioning is a high priority for Kent and Medway NHS and Social Care Partnership Trust (KMPT) whose core purpose is to assess and treat people with mental health problems. The prevention of suicide is central to this aim. It relies on the care of a patient accessing its services to be excellent from the point that a referral is received to when they are discharged. This involves responding to a referral at the right pace, according to the severity of a patient's clinical condition and the risk of a negative event occurring while they are waiting to access a service. An accurate diagnosis at assessment must be followed by effective treatment - delivered to the patient while they are in a safe environment - developed through building good relationships between the patient, their family/carers and members of the care team. This is essential for a patient safety culture within KMPT(Appendix 1).

1.2 Each patient's clinical progress must be monitored during their recovery and alternative clinical strategies employed if a patient's condition deteriorates or if they do not improve. When a patient reaches the point where they are stable, their discharge from the care team back to primary care must be co-ordinated between both services and set out in an up-to-date care plan, safety plan and crisis and contingency plans should the patient's condition deteriorate again. Sometimes, patients are referred to more than one service, or transferred between different services, within KMPT, which must be done smoothly to maintain clinical effectiveness and safety. Equally, patients are sometimes referred to services outside the organisation, such as for substance misuse treatment or for social care, where good communication between all involved is essential.

1.3 This Suicide Prevention Strategy builds on the Trust's Preventing Suicide Strategy 2012-2015, the government's National Strategy, published in 2012, 'Preventing Suicide in England' and its Annual Progress Reports. It has been developed in conjunction with a public health led Kent and Medway Suicide Prevention Steering Group, which has produced a Kent and Medway Multi-Agency Suicide Prevention Strategy 2015-2020.

1.4 The International context is set out in the World Health Organisation report 'Preventing Suicide - A Global Imperative'. The National context is provided by the Department of Health document 'Prompts for Local Leaders on Suicide Prevention' in September 2012, Public Health England's 'Public Health Outcomes Framework 2013 – 2016' in November 2013 and the National Institute for Health and Care Excellence (NICE), which issued guidance about self-harm in June 2013. In August 2013, the Chief Medical Officer's Annual Report on Public Mental Health Priorities set out that suicide prevention relies on sound backing from local authorities. This was followed in September 2014 by Public Health England's 'Guidance for Developing a Local Suicide Prevention Action Plan'.

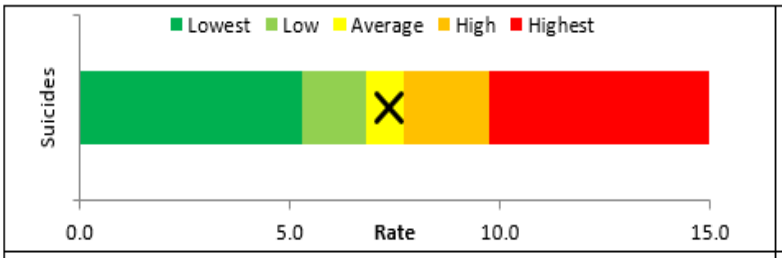
1.5 In July 2015, the annual report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) described the suicide rate in England in the general population as varying by NHS area. The lowest rates are in London and the South East, with higher rates in the North and South West. The suicide rate has been rising since low figures in 2006, mostly marked in men aged 45-54, in whom the suicide rate has risen by 37% in England.

1.6 Trends in suicide numbers and rates and associated factors and circumstances can be found in data published at the internet by NCISH.

1.7 The NCISH Trust Safety Score card has been released to Kent and Medway Social Care Partnership Trust for the years 2011 to 2013. This shows an average suicide rate compared to other mental health providers across England, the suicide rate being 7.4 per 10,000 mental health contacts.

**Trust Scorecard: Kent and Medway NHS and Social Care Partnership Trust**

The Figures give the range of results in mental health providers across England averaged between 2011-2013. The providers are grouped into quintiles with green indicating the 'safest' group and red the 'high risk' group. 'X' marks where your trust is located in the figures.




**Suicide rate**

The suicide rate in your Trust was 7.4 (per 10,000 mental health contacts*) between 2011-13 and in the **average** quintile compared to other mental health providers in England

1.8 Mood disorders, such as depression, are particularly associated with suicide in patients known to mental health services. Schizophrenia and other delusional disorders are also common primary diagnoses, as are personality disorder and drug and alcohol disorders. Co-morbid substance use is not uncommon. The Detroit model of 'zero tolerance' for suicide and the associated 'perfect depression care pathway' emphasises the importance of identifying and treating mental disorder, in this case depression. A parallel approach in England would be the prevention of preventable (avoidable) deaths and the use of a multi-faceted approach to achieve such prevention, with NICE guidance for care and treatment at its core.

1.9 Research conducted by NCISH shows that working more closely with families could prevent more suicides. Staff reported that more family involvement would have reduced the risk in 16% of cases in England. An example of how services can improve contact with families is when a patient does not attend an appointment. This provides the service with an opportunity to contact the family, check the patient's circumstances and intervene appropriately.

1.10 Physical illness is known to be a risk factor for suicide. NCISH found that around a quarter of patients who died by suicide have a major physical illness – 3410 deaths over 2005-2013 – and the figure rises to 44% in patients aged 65 and over. In most cases the illness has been present for over 12 months. In 2013 there were 445 mental health inpatients who were reported to have major physical illness and who died by suicide. This figure has risen since 2008, though the rise may reflect a greater awareness among staff of physical illness.

**NCISH individual report for KMPT, 2011 – 2013 with England and Wales context**

| | KMPT | England and Wales |
|---|---|---|
| Inpatient at time of death | < 10 | 222 (6%) |
| Died within 3 months of discharge from in-patient care | 17 (17%) | 581 (17%) |
| Non-compliant with drug treatment in the month before death * | 18 (19%) | 409 (12%) |
| Missed last contact with services | 28 (28%) | 859 (25%) |
| Primary Diagnosis<br>Schizophrenia and other delusional disorder<br>Affective disorder<br>Alcohol dependence misuse<br>Drug dependence misuse<br>Personality disorder | 18 (18%)<br>39 (36%)<br>< 10<br>< 10<br>< 10 | 581 (16%)<br>1,632 (44%)<br>288 (8%)<br>187 (5%)<br>331 (9%) |
| Method of suicide<br>Hanging, strangulation **<br>Self-poisoning<br>Carbon monoxide poisoning<br>Jumping/multiple injuries<br>Drowning **<br>Other | 34 (31%)<br>32 (29%)<br>< 10<br>17 (15%)<br>11 (10%)<br>< 10 | 1,687 (45%)<br>959 (26%)<br>54 (1%)<br>508 (14%)<br>178 (5%)<br>304 (8%) |
| History of self-harm<br>History of violence<br>History of alcohol misuse<br>History of drug misuse | 70 (65%)<br>23 (22%)<br>48 (44%)<br>38 (36%) | 2,474 (68%)<br>792 (22%)<br>1,665 (46%)<br>1,249 (34%) |
| Last contact with services within 1 week before death | 45 (42%) | 1,768 (48%) |
| •* P < 0.05<br>•** < 0.01 | | |

1.11 KMPT's 2012 Preventing Suicide Strategy's main objectives were as follows:

1. Improved clinical risk assessment and management.

2. Improved identification of relapse indicators and response (contingency plan) within care plans.

3. Enhanced Care Programme Approach (CPA) process for patients with a severe mental illness, history of self-harm or violence.

4. Improved information sharing between mental health teams and the use of the electronic patient record.

5. Seven day follow up for people discharged from mental health inpatient care.

6. Timely Mental Health Act assessments undertaken by the most appropriate clinician with access to information which informs decision making.

7. Identification of risk assessment during a section 136 Mental Health Act assessment.

8. Improved clinical risk assessments for inpatients detained under the Mental Health Act.

9. Involvement and support of carers.

10. Improved information and support for people affected by suicide.

11. Improved clinical and risk assessment training for staff.

12. Clinical supervision compliance.

1.12 Serious incidents (SI) are still being reported that show that there had not been a recent risk assessment, or that the assessment had not been adequate. There is clear guidance provided as to whether patients should be allocated to the Care Programme Approach (CPA) or a care pathway and the use of standard and enhanced CPA has now been discontinued. The RiO electronic patient record has enabled better clinical communication within and between the services of the organisation, although the operation of the electronic patient record has sometimes been hampered by technical difficulties and the rigidity of the format for inputting data, including within the risk assessment (latterly the risk summary) screens.

1.13 Seven day follow-up following discharge from inpatient admission is achieved in the vast majority of cases, although there was a slight reduction between April 2014 and April 2015. In the same timeframe, there has been considerable improvement in the percentage of CPA clients with care and crisis plans.

1.14 There have been improvements in the ways that Mental Health Act assessments are conducted with regard to the re-organisation of doctors' rotas, transformation of the Approved Mental Health Professional (AMHP) rota and ensuring that information about the patient is made available to those conducting Mental Health Act assessments.

1.15 The Patient Safety Manager has been involved in co-ordinating support to those affected by suicides.

1.16 KMPT places a high priority on clinical risk assessment training for staff, including with the introduction of the 3 tier process for assessing and managing risk, incorporating the Suicide Assessment Five-step Evaluation and Triage (SAFE-T),

which will be made available to all clinical areas. There is a related training package, 'Clinical Risk Assessment and Management Process', being cascaded to clinical teams in each of our four service lines via their quality leads, which is included as part of the induction programme for all new qualified employees. It is also available as an E-learning package which includes guidance as to how to follow the risk assessment/management process, case scenarios, videos and linked resources.

## 2 SIGN UP TO SAFETY

2.1 The NHS England Sign Up to Safety campaign has the vision of making the NHS the safest health care system in the world by aiming to deliver harm-free care for every patient every time. In order to work towards this aim all healthcare organisations have been invited to `sign up' to making pledges on the action they will take within each of the following domains:

- Put safety first
- Continually learn
- Honesty
- Collaborate
- Support

2.2 To prevent harm to patients, each organisation that has signed up has to produce a Safety Improvement Plan. The KMPT plan has been developed from Patient Safety Priorities within the KMPT Quality Account, a Patient Safety Climate Staff Survey was carried out in December 2014 and serious incident themes and trends reported in the KMPT Quality Digest. The following topics for improvement were identified:

- Clinical risk reduction (Suicides and Management of Violence)
- Safer discharge
- Medication
- Patient safety culture and risk assessment transformation

2.3 All activities relating to the Sign Up to Safety Campaign are managed by the Safety Innovation and Development Group, which reports to the Patient Safety Group.

## 3 QUALITY ACCOUNT

3.1 Every healthcare organisation is required by law to publish a Quality Account by 30 June each year, in accordance with the Quality Account Regulations 2010 in the format as described in the Quality Account Tool Kit (2011).

3.2 Within the document the healthcare organisation must describe local priorities, three for each of the quality domains: Patient Safety, Patient Experience and Clinical Effectiveness.

3.3 The responsibility for identifying and monitoring the local priorities within KMPT rests with the Trustwide Patient Safety Group, Patient Experience Group and Clinical Effectiveness & Outcomes Group, for their respective priorities. All the priorities are ratified by the Quality Committee and Trust Board.

3.4 The Patient Safety priorities for 2015 -2016 are as follows:

- Reduce all serious incidents including absences without leave (AWOL) in inpatients (of which absconding is one scenario), suicide and serious self-harm during an inpatient admission or while in treatment with a working age adult community team.

- Ensuring that all adults, children and young people are effectively safeguarded.

- Increasing health promotion smoking cessation advice and intervention to encourage people to stop smoking

3.5 The metrics for measuring the first patient safety priority, which have been taken from the South of England Patient Safety Collaborative metrics, are as follows:

- A reduction in deaths as a result of self-harm in service users on inpatient wards.

- Zero or greater than 300 days between deaths as a result of self-harm in service users in receipt of care from community teams including CRHT.

- Zero or greater than 150 days between severe harm in service users on inpatient wards.

- Zero or greater than 300 days between severe harm in service users in receipt of care from community teams.

- Zero or greater than 300 days between AWOLs and missing service users.

## 4 SAFETY, INNOVATION AND DEVELOPMENT MEETING

4.1 This meeting brings together the work of the Patient Safety Collaborative and the Sign Up to Safety meetings and reports directly to the Trustwide Patient Safety meeting. As part of this work the following work streams will be taken forward:

- Suicide and management of violence
- Safer discharge
- Medication
- Patient safety culture
- Risk assessment transformation

## 5 SCOPE

5.1 This strategy applies across all service lines and geographical areas of the Trust in order to provide safer services for those at risk of suicide. The strategy will link to

quality improvement and assurance processes within the organisation's clinical governance structure.

## 6 DUTIES AND RESPONSIBILITIES

6.1 High quality services that are equally accessible to all are fundamental to reducing the suicide risk in people of all ages with mental health problems across effective care pathways between emergency departments, primary and secondary care, inpatient and community care and on discharge.

6.2 The Trust Board and Chief Executive are charged with the delivery of effective and safe care to people referred to and under the care of the Trust and are therefore ultimately responsible for the implementation of the Suicide Prevention Strategy and associated policies and plans.

6.3 The Trust Board therefore has a duty to ensure national and local learning through experience is implemented and that clinicians have access to the resources required, including relevant training, to manage clinical risk effectively.

6.4 The Trust sets out policies based on legislation, national guidelines and best practice which serve as some of the controls to reduce clinical risks. Managers and clinicians who work with high risk groups are required to understand their roles and responsibilities, adhere to policies, undertake training and implement recommendations from national and local learning through experience.

6.5 Managers and clinicians are responsible for ensuring that the environment of care has been assessed for potential ligature points and that the findings from this 'environmental' assessment are considered during admission, assessment and review of patients who may be at risk.

6.6 The Prevention of Suicide and Homicide Group will create and monitor a Suicide Prevention Action Plan. All groups within the clinical governance framework, particularly the Service Line Clinical Governance Groups, will be collectively responsible for the success of the strategy.

## 7 AIMS AND OBJECTIVES

7.1 The principle objectives of the 2016 strategy are as follows:

7.1.1 Prioritise, identify and treat the diagnoses associated with the highest risk of suicide according to NICE guidance:

a) Depression and mixed affective states, especially those associated with anxiety and/or agitation, using ICD-10 or DSM-IV diagnostic classifications and NICE guidance (updated edition): National Clinical Practice Guideline 90.

b) Schizophrenia and other delusional disorders.

c) Personality disorder, with development of a comprehensive and uniform care pathway across Kent and Medway enabling appropriate treatment by

our services, whether they be based in community mental health teams or our specialist personality disorder service.

d) Drug and alcohol disorders, with reference to the Kent & Medway Joint Working Protocol for Co-existing Mental Health and Substance Misuse (Dual Diagnosis).

7.2 Embed risk assessment as an integral part of – and not separate to – clinical assessment, with a view to preparing a clinical risk management plan that can be formulated and shared with patients as a 'safety plan', with the SAFE-T at its centre (Appendix 2). Clinical risk assessment/management plans are conducted at first assessment, admission, whenever there is a change in risk, and at discharge (and at least six monthly). Clinical risk is reviewed when making decisions about leave and discharge from hospital.

7.3 Adopt a tiered risk assessment and risk management (safety planning) model as a standard operating procedure within the organisation's mental health services. This model will guide staff to identify patients at the highest risk of attempting suicide and allocate to them the most intensive suicide prevention plan. Adapt 'Open RiO' risk summary screens to this tiered model and use prompts and links in Open RiO to assist staff to practice to an optimal standard. The identification of risk factors will lead to a detailed suicide enquiry, focusing on ideation, plan, behaviours and intent, feelings of hopelessness or lack of control.

7.4 Organise services to promote optimal clinical and risk management for our patients. Embed a patient safety culture in initiatives such as Single Point of Access (SPA) and pod structure for Community Mental Health Teams, secondary care and specialist services. Emphasise the importance of the relationship between the patient and a mental health practitioner within a small care team. Identify the impact on patient self-harm and suicide risk of struggling services within the organisation, which may be indicated by high caseloads, staff sickness, staff turnover, vacancies, low rates for training and supervision, as well as dysfunctional line management and clinical governance. Use performance management data to identify clinical teams that are not meeting required patient safety standards and to provide them with assistance to do so.

7.5 Involve a patient's family and carers in safety planning as standard practice. Encourage the use of the "open dialogue" programme. There is nothing to prevent a member of staff from receiving information from family and carers which may assist safety planning and other aspects of care and treatment. Additionally, patients are usually willing to consent for staff members to discuss their circumstances with their family and carers, which may be most usefully conducted with the patient's active involvement in the process; when patients withhold consent or lack capacity to consent, members of staff can share information with family and carers when there are compelling reasons to do so, most commonly in order to prevent serious harm. Use the complaints process to identify deficiencies in risk assessment and management – safety planning.

7.6 Identify and manage patient characteristics that are particularly associated with suicide in addition to diagnosis (as set out in 7.1 above).

- Gender: Men are 3 times as likely to take their own lives as women
- Age: certain age groups are statistically more vulnerable

- Physically disabling or painful illnesses, including chronic pain
- People with a history of self-harm or attempting suicide
- Those with suicidal ideation, plans, behaviour and intent

7.7 Identify and manage circumstances that are particularly associated with suicide:

- Leave of absence and discharge from inpatient care, service transitions, service interfaces. The modified Snowden Model is being implemented to define responsibilities for community mental health teams and specialist services when both are providing care and treatment. (Appendix 3). Leave protocols for compulsorily admitted inpatients are being revised and admission agreements for informally admitted patients are being developed to optimise patient safety.

- Loss (including bereavement/relationship breakdown) or other stressful life event, including economic disadvantage and debt, imprisonment.

- Living alone (or will do after discharge).

- Access to lethal means, including access to ligature points on inpatient wards.

- Access to potentially lethal drugs in self-poisoning and any hoarding of drugs. Clinicians shall be aware of the importance of time-limited prescriptions where appropriate, and the benefits of compliance aids for medication, where doses are separated into compartments for day and time, prompting the patient to take their medication as prescribed and enabling staff to inspect whether doses are present or absent, which has relevance to the next contact point when assessing concordance.
- Disengagement from services, and/or lack of concordance (non-compliance) with treatment.
- When concerns are expressed by significant others, particularly family members and/or carers. When family, carers and friends become concerned that the person they care about may be at risk of suicide they will know who to contact within the mental health service and these concerns will be considered and responded to in a timely and appropriate way.
- The Kent and Medway Multi-Agency Suicide Prevention Strategy 2015 – 2020 has identified the following occupational groups as being of particular concern in Kent: construction, agriculture and road transport drivers.

7.8 Use individual and group clinical supervision to promote evidence based and reflective practice.

7.9 Offer training to underpin all of the above priorities. Support and finance staff to attend recognised suicide prevention training such as STORM and ASIST.

7.10 Promote collaborative working with other services and agencies that may encounter a suicidal person, such as primary care, accident and emergency departments, substance misuse services, prisons and social services and the Police; engage with the work of the Crisis Care Concordat to ensure that patients needing secondary care mental health services are presented for assessment in the most expedient way and are offered treatment in a timely manner.

7.11 Whenever possible, patients who need admission are to be admitted to a local ward.

7.12 Each service line has advanced the following priorities for suicide prevention:

**Acute service line:**

- For inpatients, there will be a continued focus on the management of potential ligature points, patient leave and patient observations. Strategies to Reduce Missing Patients: A practical work book (National Mental Health Development Unit 2009) may be a useful resource for clinical staff for all patients identified as having a moderate/serious risk of attempting suicide.
- Raise awareness that Crisis Resolution/Home Treatment may not be suitable for patients at high risk or those who do not have adequate family or social support, where admission to hospital may need to be arranged. The Service Line is exploring alternatives for caring for patients experiencing a crisis.

**Community Recovery service line:**

- Multi-disciplinary pod working underpinned by leadership and management and effective processes to ensure clear, accurate and prompt clinical communication and focused decision making that will deliver safe services and interventions.
- Community teams will be increasingly sensitive and responsive to the vulnerability a patient faces when proposing to transfer them out to a new service or when receiving a new patient into the service.
- Community team pods and workers will become increasingly confident and competent in engaging with the patient's family and carers whilst maintaining a good working relationship with the patient in which their rights to personal integrity and dignity and privacy and confidentially are agreed, respected and maintained.

**Forensic and Specialist service line:**

- Specialist services – to develop interface between each specialist service and other service lines, to ensure that there are no interruptions to a patient's care and treatment, which may be provided by several service lines (for example, the Community Recovery Service Line for patients with co-morbidity or the Acute Service Line where out-of-hours intervention may

be necessary). Develop the Snowden Model to manage interfaces and potential interpolations in the care provided.

- Specialist services – collaborate with other services to provide a comprehensive treatment and care pathway for patients with personality disorder.
- Secure services – ensure that inpatient environments are as safe as possible, using optimal physical, procedural and relational security, with a particular focus on preventing the use of ligature points.

**Older Adult service line**:

- Ensure that crisis intervention is available to all older adults across Kent and Medway, commensurate with services provided to other adults.
- Ensure that inpatients' leave is managed safely, including assessing a patient's risk prior to every proposed leave episode, in the context of that leave episode (whether escorted or unescorted and considering the nature of the leave and its purpose).
- Raise staff awareness of drugs used by patients in self-poisoning, ask about availability of such drugs in the patient's home environment or when unsupervised and reduce availability wherever possible.

## 8 STANDARDS FOR THE SUPPORT OF THOSE BEREAVED OR AFFECTED BY A SUICIDE

8.1 Every suicide affects families, friends, colleagues and staff. Family and friends bereaved by a suicide are at increased risk of mental health and emotional problems and at potentially higher risk of suicide themselves.

8.2 Timely emotional and practical support for families affected by suicide is essential to help the grieving process and support recovery.

8.3 Support for individual staff and teams should be provided in the form of supervision.

## 9 STRATEGIC PARTNERSHIP WORKING

9.1 The majority of people who take their own lives are not known to mental health services at the time of their death. (In 2013, out of the 182 people who died by suicide in Kent, 43 had had contact with KMPT in the previous 12 months). We are committed to working with other agencies that can have a positive impact on the behaviour of both high-risk groups and the wider population. KMPT provides representatives to the Kent and Medway Multi-Agency Suicide Prevention Steering Group led by Kent County Council Public Health and contributes to a Multi-Agency Suicide Prevention Strategy involving Primary Care, Clinical Commissioning Groups (CCGs), NHS England and Kent Police.

9.2 The KMPT Communications Team works with key partners to encourage them to provide information about sources of support and help lines when reporting suicide and suicidal behaviour, and to be sensitive to the subject and those affected.

## 10 GOVERNANCE ARRANGEMENTS

10.1 There are three Trust-wide clinical quality groups: Patient Safety, Patient Experience and Clinical Effectiveness and Outcomes. Each reports to the Quality Committee. The Prevention of Suicide and Homicide Group reports to the Trustwide Patient Safety Group. Together these groups produce a clinical safety, quality assurance and monitoring framework of the effectiveness and quality of clinical care delivered by KMPT services, measured by clinical data made available from service delivery, and overseeing the implementation of action plans to improve clinical care, where appropriate.

## 11 ROLE OF THE PREVENTION OF SUICIDE AND HOMICIDE GROUP

11.1 The Prevention of Suicide and Homicide Group will conduct surveillance of the national and local context regarding suicide prevention and report to the Patient Safety Group on the following themes:

11.1.1 Creating and monitoring the progress of the Trust's Suicide Prevention Strategy and Suicide Prevention Action Plan.

11.1.2 Exploring the conclusions and recommendations of the National Confidential Inquiry into Suicide and Homicide by people with Mental Illness (NCISH), to ensure that recommendations are implemented by the Trust.

11.1.3 Obtaining local data from NCISH to benchmark data for the Trust against that for other mental health service providers in England.

11.1.4 Assimilating conclusions and recommendations from International and National initiatives, including other inquiries, in order to implement key messages.

11.1.5 Researching academic journals for publications on suicide and homicide in populations in England and Wales, for messages that may be applicable in Kent and Medway.

11.1.6 Monitoring outcomes of investigations by Trust adverse event reporting systems (Serious Incidents [SIs] and SI Learning Reviews) relating to self-harm, attempted suicide and completed suicide, assisting in the process of ensuing their recommendations are followed, in liaison with other KMPT patient safety groups.

11.1.7 Identifying trends from Trust weekly 'Flash Report' and monthly 'Quality Digest' to enable rapid investigation and resolution.

11.1.8 Instigating a new audit within KMPT to identify themes, and to help address problematic practices.

11.1.9 Work with the Kent & Medway Public Health Information Team to identify any local themes and trends in suicides, to enable the formulation of an action plan to address issues that emerge for the Trust.

11.1.10 Learning lessons from Coroners' Inquests where suicide is the mode of death – including where a Preventing Future Deaths order is made – and, where relevant, when an open verdict is recorded.

11.1.11 Accepting items for discussion and action from members of the Prevention of Suicide and Homicide Group, and other stakeholders.

11.1.12 Accepting submissions from the Complaints Department that raise relevant issues.

## 12 OPERATIONALISING THE SUICIDE PREVENTION STRATEGY

1.1. It is essential to implement a strategy such as this by setting achievable and measurable objectives, to indicate the success of suicide prevention in KMPT and set up rapid alerts to show when a service may be struggling. Direct and proxy variables will be measured in order to assess the effectiveness of suicide prevention.

1.2. The absolute measure of success is the prevention of deaths by suicide in people in contact with our mental health services. However, this is a statistically insensitive approach in a data set with relatively small numbers when compared with the total patient population, where there is some expected fluctuation year to year. Proxy indicators of success may include:

- Achieving percentage target waiting times from referral to assessment (four weeks) and referral to treatment (18 weeks).
- Allocation of a key worker / lead mental health professional to each patient.
- Percentage of patients with valid CPA care plan or plan of care and line manager assessment of care plan adequacy (three per month).
- Percentage of patients with risk assessment and risk management plans ('safety plans'), with quality of the risk assessment and safety plan determined by line manager (3 per month).
- Percentage of patients with a crisis plan.
- Percentage of staff who have clinical supervision at least once a month, to include discussion of the quality of care plans, crisis plans and risk assessment/management plans (safety plans) – identified by supervision audits.
- Mandatory training figures for clinical risk assessment and management.
- Percentage of clinical staff who have attended external suicide prevention training.
- Percentage of patients readmitted as an emergency within 28 days of discharge.
- Number of unplanned absences (absent without leave, AWOL, including absconds) for patients detained under the Mental Health Act.

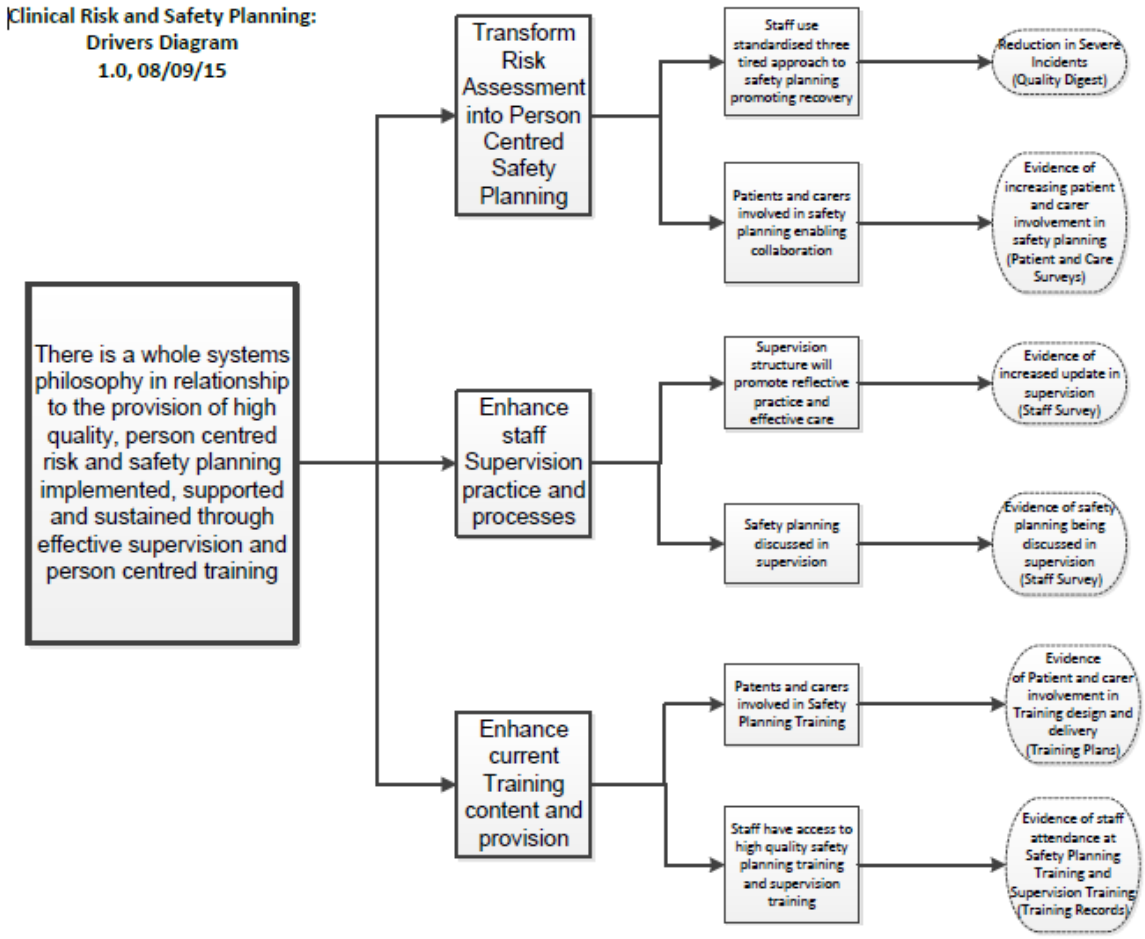
- Analysing incidents involving self-harm and attempted/completed suicide, learning lessons and disseminating them throughout the Trust. Level 4 and 5 serious incidents will be discussed at the Trust Wide Patient Safety and Mortality Group. For lower level incidents, encourage the use of incident investigation and root cause analysis tools (including for near misses and incidents that are pre-indicators to level 4 and 5 incidents).

## 13 STAKEHOLDER INVOLVEMENT AND CONSULTATION

13.1 Stakeholders are identified as:

- Patients, their families and carers.
- KMPT clinicians and managers, trainers and communication team.
- Kent County Council mental health professionals and managers.
- Kent and Medway Multi-Agency Suicide Prevention Steering Group led by Kent County Council Public Health and involving Service User and Carer representatives, Primary Care, Substance Misuse Service Providers, The Samaritans, Clinical Commissioning Groups (CCGs), NHS England and Kent Police.

## APPENDIX 1 RISK AND SAFETY PLANNING DIAGRAM



## APPENDIX 2 SAFE-T

## SAFE-T


SAFE_T card original (2).pdf

**APPENDIX 3 MODIFIED SNOWDEN M**

Modified Snowden model illustrating interface between local Community Mental Health Teams and Specialist Services (non-forensic).

*Higher risk/morbidity*

Tier 4 = Specialist Service inpatient beds…… **OATS beds** – personality disorder, eating disorders, mother and infant mental health services, neuropsychiatry

Tiers 2 and 3 combined…… **Shared community care** led by local CMHT when Specialist Service needs combine with co-morbidity and CMHT "caseness" exists (CPA)

*[Tier 2 also comprises general psychiatry inpatient services for younger and older adults]*

Tier 3 = Specialist Service in the community

Tier 2 = CMHT

| **Tier 3 – Specialist Service** | **Tier 2 – local CMHT** |
|---|---|
| **Sole community care** from Specialist Service where Specialist Service needs exist but no CMHT "caseness" exists (non-CPA) | **Sole community care** from CMHT where CMHT "caseness" exists but no Specialist Service needs exist (either CPA or non-CPA) |

Lower risk/morbidity

*[Tier 1 comprises primary care services]*