Somerset Partnership NHS
NHS Foundation Trust

SUICIDE PREVENTION STRATEGIC PLAN 2014 - 2017

Version:	1
Ratified by:	Senior Managers Operational Group
Date ratified:	April 2015
Title of originator/author:	Suicide Prevention Group
Title of responsible committee/group:	Clinical Governance Group
Date issued:	**August 2015**
Review date:	**March 2017**
Relevant Staff Groups:	All staff groups

This document is available in other formats, including easy read summary versions and other languages upon request. Should you require this please contact the Equality and Diversity Lead on 01278 432000

DOCUMENT CONTROL

Reference CS/Apr15/SPS	**Version** 1	**Status** Final	**Author** Divisional Manager, South Somerset/ Suicide Prevention Group Chair
Amendments	New strategy		
Document objectives: To present a Trust strategy for suicide prevention			
Intended recipients: All Trust staff			
Committee/Group Consulted: Suicide Prevention Group			
Monitoring arrangements and indicators: Clinical Governance Group			
Training/resource implications: Advanced risk training for professionally registered mental health practitioners			

Approving body and date	Clinical Governance Group	Date: July 2014
Formal Impact Assessment	Impact Part 1	Date: March 2015
Clinical Audit Standards	NO	Date: N/A
Ratification Body and date	Senior Managers Operational Group	Date: April 2015
Date of issue	**August 2015**	
Review date	**March 2017**	
Contact for review	Divisional Manager (South Somerset)/Suicide Prevention Group Chair	
Lead Director	Director of Nursing and Patient Safety	

CONTRIBUTION LIST Key individuals involved in developing the document

Name	Designation or Group
Carolyn Smith	Divisional Manager/Suicide Prevention Group Chair
Jayne Haynes	Divisional Manager
Gina Bird	Professional Lead for Mental Health Nursing in the Community
Jess Popham	Community Mental Health Nurse
Christine Picton	Wessex House Ward Manager
Jane Yeandle	Head of Taunton and West Somerset Division (Acting)
Paul Watts	Head of Mental Health Nursing/Head of Patient Safety
Tim Young	Inpatient Services Manager
Paul Milverton	Deputy Head of Division, Mendip
Catherine Bunce	Divisional Secretary

CONTENTS

Section	Summary of Section	Page
Doc	Document Control	2
Cont	Contents	3
1	Introduction	4
2	Purpose & Scope	5
3	Duties and Responsibilities	5
4	Explanations of Terms used	6
5	National Context	7
6	National Suicide Rate	8
7	Somerset Suicide Rate and Trends	8
8	Somerset Partnership's Strategic Approach to Suicide Prevention	10
9	Training Requirements	22
10	Equality Impact Assessment	22
11	Monitoring Compliance and Effectiveness	22
12	Counter Fraud	22
13	Relevant Care Quality Commission (CQC) Registration Standards	23
14	References, Acknowledgements and Associated documents	23
15	Appendices	25
Appendix A	Suicide Death Rates	26
Appendix B	Trust Implementation Plan – Action Plan 2014-2017	33

1. INTRODUCTION

1.1 "In England, one person dies every two hours as a result of suicide. When someone takes their own life, the effect on their family and friends is devastating. Many others involved in providing support and care will feel the impact" (DH, 2012 a).

1.2 "Suicide is not inevitable and there are many ways in which mental health services can improve clinical practice to reduce suicide among mental health patients" (National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH, 2013).

1.3 In 2012, 4,513 people aged 15 and over ended their lives through suicide in England. For a decade, suicide rates decreased however over the past 4 years, the suicide rate has risen (Department of Health, 2014 – revised).

1.4 In Somerset, the suicide rate is lower than the national average with 8.2 deaths per 100,000 in 2012 compared with 10.4 deaths per 100,000 in England as a whole. Between 2001 and 2011, 187 people who ended their life by suicide were in contact with Somerset Partnership NHS Foundation Trust within the year prior to their death.

1.5 In 2012, the Government launched 'Preventing Suicide in England: a cross-government outcomes strategy to save lives'. The strategy is clear that suicide prevention is not the sole responsibility of any one sector or of health services alone. Indeed, only around a quarter of people who die from suicide have been in contact with mental health services during the previous year (NCISH, 2013). Suicide is often the end point of a complex history of risk factors and distressing events. The prevention of suicide therefore needs to address this complexity (DH, 2012 a).

1.6 Suicide prevention activities in Somerset are monitored by the multi-agency Somerset Suicide Prevention Advisory Group which works to the overarching Somerset Suicide Prevention Strategy. The overall aim of the 2013-2016 Somerset Strategy is to achieve:

- a reduction in the suicide rate in the general population in Somerset;
- better support for those bereaved or affected by suicide.

1.7 This document, the Somerset Partnership NHS Foundation Trust Suicide Prevention Strategic Plan, sits underneath, and is aligned to, the overarching Somerset Strategy. It sets out the Trust's strategic aims and objectives for preventing suicide amongst the people that work with and for the Trust. This includes Trust patients, families, carers and staff.

1.8 Both the Somerset strategy and Somerset Partnership strategic plan follow a similar framework to the national 'Preventing Suicide in England' strategy which is based on the following six areas for action:

- reduce the risk of suicide in high risk groups;

- promote mental health and wellbeing in the population as a whole;
- reduce access to the means of suicide;
- provide better information and support to those bereaved or affected by suicide;
- support the media in delivering sensitive approaches to suicide and suicidal behaviour;
- support research, data collection and monitoring.

The Trust established a Suicide Prevention Group in 2013 which is responsible for monitoring implementation of this strategy.

2. PURPOSE & SCOPE

2.1 The Trust's strategic approach to suicide prevention is set out in this document. It applies to all community health and mental health services and staff across the organisation.

2.2 Suicide prevention is 'everyone's business and the Trust aims for all staff to be aware that they have a responsibility in identifying and reducing the risk of suicide.

2.3 The Trust supports and is actively engaging with NHS South of England in a challenging Zero Suicide programme in the South West by 10 October 2018 (World Suicide Prevention Day). It is acknowledged that risk of suicide cannot be eliminated; however the Trust is committed to exploring potential ways to work towards this challenging aspiration in partnership with a wide range of organisations in the region.

2.4 While people with a history of self-harm are identified as a high risk group, this strategy, in line with the national strategy, is specifically about the prevention of suicide rather than non-fatal self-harm (DH, 2012 a).

3. DUTIES AND RESPONSIBLITIES

3.1 The Suicide Prevention Strategic Plan should be read alongside the Clinical Assessment and Management of Risk of Harm to Self and Others policy, the Serious Incidents Requiring Investigation (SIRI) policy and the Risk Management Strategy.

The Trust is risk aware and aims for all staff to be aware they have a responsibility to identify and reduce the risk of suicide.

3.2 The Board endorses the Suicide Prevention Strategic Plan and has in place an Assurance Framework to manage and minimise significant risks to the organisation's principal objectives and oversees any subsequent reviews of the Suicide Prevention Strategy.

3.3 The Chief Executive retains overall responsibility for risk management across the organisation and provides ongoing support to risk management and related functions.

3.4 The Director of Governance and Corporate Development has devolved responsibility for risk management in the Trust.

3.5 An Organisational Committee Structure demonstrating the governance accountability and reporting arrangements of the Trust's Governance Groups/Sub-groups, helps manage the delegated responsibility for implementing risk management systems within the Trust. Each Group/Sub-group is required to develop and review Terms of Reference that include reporting arrangements, which are approved and monitored by the Integrated Governance Committee to which it is accountable.

3.6 The Chair of the Integrated Governance Committee provides a six monthly assurance report to the board in respect of its compliance and governance functions.

3.7 The Clinical Governance Group oversees the organisation's clinical governance agenda by ensuring that appropriate systems and processes are in place to provide evidence of continual improvement in the quality of services.

3.8 The Clinical Governance Group meets monthly and receives and monitors progress against agreed quality indicators, triangulating this data with patient safety incidents, complaints and Patient Advice and Liaison Service (PALS) in order to assess the organisation Quality "temperature".

3.9 The Trust Suicide Prevention Group provides a quarterly report to the Clinical Governance Group. The report is also submitted to the Serious Incidents Requiring Investigation (SIRI) Group which provides a further quarterly report to the Clinical Governance Group.

4. EXPLANATIONS OF TERMS USED

Suicide

4.1 There is no universally accepted definition of suicide. A broad definition is *'a fatal act of self-harm with a conscious intent to end life' (DH, 1999).* Not all suicides are preceded by suicidal behaviour and sometimes, suicide can be an impulsive act or occur in a state of panic.

4.2 Suicide is complex; there is no single reason why people end their lives by suicide. Suicide is often as a result of problems building up where the person can see no other way to cope with what they are experiencing.

Self-harm

4.3 Self-harm is *'a non-fatal act whether physical, drug overdose or poisoning, done in the knowledge that it was potentially harmful and in the case of drug overdose that the amount taken was excessive'* (DH, 1999).

4.4 The intent of self-harm may be to stop or interrupt conscious experiences or be an appeal, or request for help. Self harm can operate

as a way of coping or surviving and coping with difficult feelings. It can take many forms including poisoning and cutting. Many acts of self-harm do not have suicidal intent and some deaths which are classified as suicide may result from acts which were not intended to cause death or from where the motivation (suicidal intent) was ambiguous.

4.5 Conversely, some acts of self-harm may have suicidal intent but may have been unsuccessful through factors such as rescue by others and insufficient knowledge about the chosen method.

4.6 While many acts of self-harm are not intended to end life, self-harm is closely linked with completed suicide. Self-harm is one of a range of risk factors associated with suicide however the majority of people who self-harm do not go on to take their own life through suicide.

4.7 This strategic plan focuses only on the aspects of self-harming behaviour that might be considered as an indication of risk of suicide. It is recognised that there are other dimensions and manifestations of self-harm that are not covered within the scope of this strategy. In addition, it is noted that for people with dementia, self-harming and suicidal behaviours may be intentional or unintentional.

Service users

4.8 People who use the services of the Trust are referred to within this strategy as ‘patients’. It is acknowledged that terminology to describe people using health and social care services is contested. The term ‘patients’ is used however as it is consistent with the terminology used in the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH, 2013) which provides comprehensive national data on suicide.

5. NATIONAL CONTEXT

5.1 *Preventing Suicide in England: a cross-government outcomes strategy to save lives* (DH, 2012 a*)* aims to reduce the suicide rate and improve support for those affected by suicide. The new strategy outlines six areas for action which are outlined above.

5.2 There are two further key strategy documents that, in combination with *Preventing Suicides in England* (DH, 2012 b), take a public health approach using general and targeted measures to improve mental health and wellbeing and reduce suicides across the whole population.

5.3 *Healthy Lives, Healthy People: Our strategy for public health in England* (2010) gives a new, enhanced role to local government and local partnerships in delivering improved public health outcomes.

5.4 *No health without mental health: A cross-government outcomes strategy for people of all ages* (2011) is key in supporting reductions in suicide amongst the general population as well as those under the care of mental health services. The first agreed objective of *No health without*

mental health aims to ensure that more people will have good mental health by:

- improving the mental wellbeing of individuals, families and the population in general;
- working towards fewer people of all ages and backgrounds developing mental health problems;
- continuing to work to reduce the national suicide rate.

5.5 *No health without mental health* includes new measures to develop individual resilience from birth through the life course, build population resilience and social connectedness within communities.

5.6 From April 2013 local responsibility for coordinating and implementing work on suicide prevention became an integral part of local authorities' new responsibilities for leading on local public health and health improvement. Health and Wellbeing Boards support local partnerships alongside determining local needs and assets.

5.7 The stigma associated with mental health problems can form a barrier to people seeking and accessing the help that they need thus increasing isolation and the risk of suicide. The need to address this is recognised through the Government and local authorities supporting the national mental health anti-stigma and discrimination Time to Change programme.

6. NATIONAL SUICIDE RATE

6.1 In 2011 there were 6,045 suicides in people aged 15 and over in the UK, an increase of 437 compared with 2010.

6.2 The UK suicide rate increased significantly between 2010 and 2011, from 11.1 to 11.8 deaths per 100,000 population.

6.3 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).

6.4 The highest suicide rate was in males aged 30 to 44 (23.5 deaths per 100,000 population in 2011).

6.5 The suicide rate in males aged 45 to 59 increased significantly between 2007 and 2011 (22.2 deaths per 100,000 population in 2011).

6.6 Female suicide rates were highest in 45 to 59-year-olds in 2011 (7.3 deaths per 100,000 population).

(Department of Health, 2014 – revised).

7. SOMERSET SUICIDE RATE AND TRENDS

7.1 The overall Somerset rate in 2011/12 is 8.2 deaths per 100,000 compared to England overall, where the rate is 10.4 deaths per 100,000.

Within the South West, the 2011/12 suicide rate is 11.9 deaths per 100,000 (ONS, 2013, see Appendix A, Figure 1).

7.2 Figure 2 (Somerset County Council, 2013, see Appendix A) provides a comparison between the directly age standardised suicide rates in England, the South West and Somerset.

7.3 Between 2007-2012 Somerset recorded 269 suicides or open verdicts with an average of 45 deaths per year. The highest number of deaths occurred in 2010 and 2011 at a total of fifty deaths. Figure 3 (Somerset County Council, 2013, see Appendix A) provides a breakdown of suicides per year in Somerset since 1993. Figure 4 (Somerset County Council, 2013, see Appendix A) provides the break down by district related to rates and numbers of suicides since 2007.

7.4 Of the total number of suicides in Somerset between 2007- 2012, 76% were Male and 24% were Female. This is consistent with the 3:1 ratio reported nationally.

7.5 Men and women aged 75+ were most at risk of completing suicide; the ratio of attempts to completed suicide is lower than for younger age groups. Figure 5 (Somerset County Council, 2013, see Appendix A) shows the suicide rate by age and gender for 2007-2012 in Somerset, indicating that while more deaths are in people aged 35-64, the there are reasonably similar rates for all age groups above 24.

7.6 The most common means of completing suicide was hanging followed by overdosing. Women used both methods equally often. Hanging was the most common method for men who tend to use more violent methods such as jumping and the use of firearms. Figure 6 (Somerset County Council, 2013, see Appendix A) illustrates causes of death by gender in Somerset.

7.7 Figure 7 (Somerset County Council, 2013, see Appendix A) provides cause of death by age group in Somerset. Hanging was the most common method for each age group. Those aged over 75 used a wider variety of methods such as intentional self-poisoning by exposure to unspecified chemicals.

Patient Suicide

7.8 Patients with mental illness are at a greatly increased risk of suicide. Approximately 90% of those who die by suicide are suffering from a psychiatric disorder at the time of death (Kapur, 2009).

a. One quarter of people who end their life by suicide in the UK have had contact with mental health services within the previous 12 months.

b. Between 2001 and 2011, the most common methods of suicide by patients were hanging, self-poisoning, and jumping/multiple injuries

whereas the number of deaths by self-poisoning, carbon monoxide (CO) poisoning, and drowning decreased.

c. There was also a fall in the number of deaths by firearms (from an average of 15 deaths in 2000-2001 to 5 deaths in 2009-2010). Numbers remained stable for hanging, jumping/multiple injuries, and cutting/stabbing.

d. The most common substances used in deaths by self-poisoning were opiates (21%), tricyclic antidepressants (16%) and paracetamol/opiate compounds (13%).

e. There was a decrease of self-poisonings by tricyclic antidepressants and paracetamol/opiate compounds over the report period (NCISH, 2012).

7.9 In-patient suicides reduced by 58% between 2001 and 2011, however there has been around a 60% increase in suicides for patients under the care of crisis resolution/home treatment teams (NCISH, 2012). While significant safety measures on in-patient wards are likely to be correlated with the reduction in in-patient suicides, the increase in patients under the care of crisis resolution/home treatment teams alongside a reduction in in-patient beds, may explain, in part, the dramatic rise in completed suicide by crisis resolution/home treatment team patients.

8. SOMERSET PARTNERSHIP'S STRATEGIC APPROACH TO SUICIDE PREVENTION

8.1 Somerset Partnership's strategic approach to suicide prevention follows the six areas for action in the national 'Preventing Suicide in England' (HM Government, 2012) strategy:

- reduce the risk of suicide in high risk groups;
- promote mental health and wellbeing in the population as a whole;
- reduce access to the means of suicide;
- provide better information and support to those bereaved or affected by suicide;
- support the media in delivering sensitive approaches to suicide and suicidal behaviour;
- support research, data collection and monitoring.

8.2 Area One: Reduce the Risk of Suicide in High Risk Groups

Who are the high risk groups?

8.2.1 The national strategy (DH, 2012 a) identified the following groups of people as being at a higher risk of suicide than the general population. These include, but may not be limited to:

- males, particularly young and middle-aged men (35-49 years);
- people in the care of mental health services, including inpatients;
- people with a history of self-harm;
- people in contact with the criminal justice system;

- specific occupational groups, such as doctors, nurses, veterinary workers, farmers and agricultural workers.

What do we know about reducing suicide among high risk groups?

8.2.2 In-patient suicides reduced by 58% between 2001 and 2011, however there has been around a 60% increase in suicides for patients under the care of crisis resolution/home treatment teams (NCISH, 2013 b).

8.2.3 Nine national recommendations for safer services, made by the National Confidential Inquiry into Suicide and Homicide (NCISH, 2013) were found to have reduced the suicide rate in Trusts that implemented the majority of them. The recommendations were:

- removal of ligature points on in-patient wards;
- community services include an assertive outreach team;
- community services include 24 hour crisis teams as a point of access;
- follow-up within seven days of discharge from in-patient care;
- written policy on management of patients who refuse treatment;
- written policy on patients with a ‘dual diagnosis’;
- written policy on sharing information about risk with criminal justice agencies;
- written policy on multi-disciplinary review and information sharing with families after a suicide;
- front-line clinical staff receive training in the management of suicide risk at least every three years.

8.2.4 The recommendations associated with the largest decrease in suicide rates after implementation (1997-2006) are presented below.

Recommendations	**% fall in suicide rates**
24 hour crisis teams	18%
Policy on multi-disciplinary review following suicide	10%
Policy on patients with dual diagnosis	9%

8.2.5 Subsequent research examined 17 recommendations linked to changes in mental health services and the impact of implementation on suicide rates between 1997 and 2011.

<u>Percentage fall in suicide rates per 10,000 patients before and after implementation of individual aspects of services (implementing trusts)</u>

Recommendation or service change	**% fall in suicide rates after implementation**
Ward safety	
Removal of non-collapsible curtain rails	17.4%
Re-design/removal of low lying ligature points	22.1%
Community services	

Community services include an assertive outreach team	20.6%
Community services include a crisis resolution/home treatment team	21.9%
Training	
Clinical staff receive training in management of suicide risk	18.9%
Policies	
Policy regarding response to in-patients who abscond	26.6%
Policy on the follow-up of post discharge patients	16.2%
Policy on patients who are not taking medication as prescribed	20.7%
Policy on the management of patients with dual diagnosis	24.9%
Policy on information-sharing with criminal justice agencies	24.0%
Policy on multi-disciplinary review and information sharing with families	23.5%
Policy on the formal transfer of care from child and adolescent services (CAMHS) to adult services	23.1%
NICE guidance	
Mechanism for implementing NICE guidelines	21.2%
NICE self-harm guidelines	22.9%
NICE schizophrenia guidelines	20.9%
NICE depression guidelines	25.5%

8.2.6 Additional research was undertaken to examine the impact of integrating specialist teams, such as assertive outreach and early intervention in psychosis teams, into larger community mental health teams. The findings also showed that “Trusts that merged their specialist teams…had higher suicide rates after merging compared to those trusts that kept these teams, although the absolute difference was small (13%) and did not reach statistical significance”. (NCISH, 2013 b).

8.2.7 Evidence from the United Kingdom demonstrates that multiple service level interventions are required to reduce the rate of suicide in the patient population.

8.2.8 Suicide prevention projects from the United States may tentatively contribute to the body of evidence. A systems approach alongside evidence based clinical practice appears to evidence significant reductions in suicide rates. It is however noted that robust studies evaluating the impact of these projects are limited at the time of writing. Examples are the US Air Force Suicide Prevention Programme (1996-2002), the Central Arizona Programmatic Suicide Deterrent System (2009 to present) and the Henry Ford System ‘Perfect Depression Care’ (2001 to present). In the Henry Ford System, the suicide rate for patients

on the Depression Care programme is reported to have reduced from 75 per 100,000 patients in 2000, to 22 per 100,000 in 2002 to 2005 and to zero over the following two years. Within the three organisations cited, suicide is conceptualised as a 'Never Event' where every suicide is preventable.

What is the Trust Implementation Plan?

Suicide prevention is 'everyone's business

8.2.9 The Trust provides a range of community health and mental health services. As only around a quarter of people who die from suicide in Somerset have been in contact with specialist mental health services during the previous year, the Trust's approach to suicide prevention is to make it 'everyone's business' within the organisation to increase opportunities for preventative interventions. Community health staff should contact their local mental health assessment for advice if they are concerned that a patient is at risk of suicide. If the risk of suicide appears to be immediate, a 999 call to the police should be made without delay.

Implementation of national recommendations for safer services that were found to reduce the suicide rate in Trusts that implemented them (NCISH, 2013 b)

Ward Safety

8.2.10 The Trust has a Ligature Point Management Policy and the Head of Division with responsibility for inpatient mental health services, will continue to satisfy themselves that annual ligature audits are undertaken or sooner if changes are made to the environment.

Community Services

8.2.11 Assertive outreach services are provided seven days a week, countywide for people with serious mental illness who are at risk of losing contact with mental health services

8.2.12 Crisis teams provide a seven day service from 8.00 to 20.30. Overnight, a night assessor provides a psychiatric liaison service to the two district general hospitals in Somerset. The Trust aspires to provide a 24 hour crisis service and will advocate for increased funding to extend the service from the Clinical Commissioning Group as crisis team funding in Somerset is significantly below the national average. It is noted that CQC have announced plans to start a thematic review of access to crisis care by the end of 2013/14 (CQC, 2014). ***(Action – see appendix B)***

8.2.13 The Trust will continue to monitor follow-up within seven days of discharge from in-patient care. Seven day follow-up is currently a CQUIN target and monitoring will continue through internal CQUIN monitoring processes. ***(Action - see appendix B)***

Policies

8.2.14 The Trust has the following policies that are consistent with national recommendations:

- Clinical Assessment and Management of Risk of Harm to Self and Others Policy which includes sharing information about risk with criminal justice agencies;
- AWOL (Detained Patients Absent without Leave) Policy including Missing Persons Guidance;
- No Response Policy;
- Dual Diagnosis Policy;
- Recovery Care Programme Approach (RCPA) Policy which includes the formal transfer of care from child and adolescent services (CAMHS) to adult services and seven day follow up arrangements;
- the Trust has written policies relevant to sharing information with families after a suicide (Serious Incidents Requiring Investigation (SIRI) Policy and Procedure and Being Open and saying sorry when things go wrong Policy).

8.2.15 Multi-disciplinary review within teams following a suicide is not included in Trust policy; consideration will be given to this being implemented to support learning via the SIRI Group. ***(Action – see appendix B).***

8.2.16 It is recommended that the Medicines Management Group consider including a section on managing non-compliance with medication in the Medicines Policy. ***(Action – see appendix B).***

8.2.17 The Trust will develop a policy (or incorporate in an existing policy) on the management of patients who refuse treatment. In addition to NCISH (2013) recommendations, this reflects the judgement in Rabone v Pennine (2012) where the Supreme Court ruled that article 2 of the European Convention on Human Rights was contravened after the trust failed to take steps to protect the life of the patient by allowing her to go home. The RCPA policy also requires strengthening in relation to clinical guidance for 'Did Not Attend' (DNAs) and disengagement from mental health services. The RCPA Group will be asked to consider implementation of these recommendations. **(Action – see appendix B).**

NICE Guidance

8.2.18 The Trust will continue to monitor compliance with, and implementation of NICE guidance through, Best Practice Groups and the Clinical and Social Care Effectiveness Group. ***(Action – see appendix B).***

8.2.19 Schizophrenia guidelines will be implemented and monitored through the Psychosis/Schizophrenia Best Practice Group. Self-harm and depression guidelines will be implemented and monitored through the Adult Mental Health Community Services Coordination and Best Practice Group and Older Persons Mental Health Community Services Coordination and Best Practice Group. ***(Action – see appendix B).***

8.2.20 The Trust will develop training for front-line mental health staff in assessment and management of self-harm in line with NICE guidance on self-harm. This follows a recommendation from the Adult Mental Health Best Practice Group. ***(Action – see appendix B).***

Training

8.2.21 A one day, advanced assessment and management of risk training course for front line, professionally registered mental health staff was implemented in 2013. This training is a mandatory requirement every three years except where line managers assess and sign off competency for individual practitioners. Assessment and management of suicidal thoughts, behaviours and intent are key components of the course. Working with confidentiality and sharing information with families and carers also features in the course to reflect lessons learned from SIRI reviews. The course is relevant for practitioners working in teams across all age groups including CAMHS and older persons mental health teams.

8.2.22 Adapted risk assessment and management training courses will be delivered for Talking Therapies staff and targeted groups of staff working within community health teams. ***(Action – see appendix B).***

8.2.23 Non-professionally registered front line front line mental health staff are required to undertake a half day training session on management of risk every 3 years.

South West Quality and Patient Safety Improvement Programme (In-Patient Mental Health)

8.2.24 The Trust will continue working with NHS South of England to develop work streams that have been adapted and extended from the South West Quality and Patient Safety Improvement Programme for Mental Health. ***(Action – appendix B)***

8.2.25 The ultimate goal is to develop a safer system for patients in which every member of staff understands their role in delivering safer care and works towards achieving that goal every day. This will be achieved by placing emphasis on improving systems, working towards excellence in every system and engaging all clinical and non clinical front line staff in the changes.

8.2.26 Work is building on the Seven Steps to Patient Safety in Mental Health (2008).

- Step 1: Build a safety culture;
- Step 2: Lead and support your staff;
- Step 3: Integrate your risk management activity;
- Step 4: Strengthen reporting in mental healthcare;
- Step 5: Involve and communicate with service users and the public;
- Step 6: Learn and share safety lessons;
- Step 7: Implement solutions to prevent harm.

8.2.27 The Trust will continue to implement and roll out the following work streams in mental health in-patient wards:

8.2.28 An Absent without Leave (AWOL) semi structure questionnaire developed from the work of Professor Len Bowers, has been piloted with

patients and family members and will be rolled out across other in-patient wards. ***(Action – see appendix B)***

8.2.29 A pilot to obtain views from patients about whether they feel included in decisions about their care has been undertaken. This will be rolled out across in-patient wards to promote person and family centred care. ***(Action – see appendix B)***

8.2.30 A resource directory for patients, families and carers has been developed and will be implemented in in-patient wards across the Trust. ***(Action – see appendix B)***

8.2.31 Improved safety measures for medicines reconciliation on admission and discharge are being developed for all in-patient wards. ***(Action – see appendix B)***

8.2.32 Photographic identification is being implemented in in-patient wards to improve safety for the administration of medication. ***(Action – see appendix B)***

8.2.33 The SBAR tool for communication was implemented in one division to promote safer handovers and transitions from one care setting to another. Consideration will be given to rolling out implementation across mental health services in the Trust. ***(Action – see appendix B)***

8.2.34 As the suicide rate has increased in community settings, the Trust will need to roll out relevant work streams from the Patient Safety Improvement Programme into community teams. ***(Action – see appendix B)***

Whole Service Approaches

8.2.35 The Trust will implement the 'Safer mental health services: a self-assessment toolkit' (NCISH, 2013 c) which provides practical steps for professionals and managers to improve safety and reduce risks. CQC will be expecting services to use the toolkit to review their practice and implement action plans to address any gaps in provision locally (CQC, 2014). ***(Action – see appendix B)***

8.2.36 The Trust will consider the development of a Suicide Prevention and Self-Harm Care Pathway; this will raise awareness that people who self-harm are a high risk group in relation to suicide, support implementation of evidence-based practice and serve as an audit tool. ***(Action – see appendix B)***

8.2.37 Opportunities will be explored to improve formulation based psycho-social assessments as recommended by NICE (2011) to provide more comprehensive understandings of patients' difficulties which lead to effective outcome focused care planning. Formal training, workshops and supervision approaches will be considered to improve formulation skills in a way that is achievable for front-line staff. ***(Action – see appendix B)***

8.2.38 While checklists and tools have a role in the assessment and management of suicidality, over-reliance on them can be a barrier to the development of therapeutic relationships. Relational approaches, where checklists and tools are used within therapeutic relationships, are advocated by the Trust.

8.2.39 The Trust will continue to provide evidence-based psychological therapies including Cognitive Behavioural Therapy, Cognitive Analytic Therapy and Dialectical Behavioural Therapy. ***(Action – see appendix B)***

8.2.40 The Trust has an aspiration to extend service provision for people following suicide attempts, particularly for people who have been discharged from mental health services. Providing follow-up letters and postcards has shown some beneficial effects outside the UK in reducing suicide. The Suicide Prevention Group acknowledges that capacity needs to be built within the service to offer extended services but aims to consider potential opportunities. ***(Action – see appendix B)***

8.2.41 The Trust will continue to provide a complex care review panel consisting of senior mental health managers to support teams and practitioners with care planning and decision-making for high risk patients. ***(Action – see appendix B)***

8.2.42 A complex care management system (over and above care coordination) is required for high risk, very complex cases where multiple services from the Trust and other organisations are involved to mitigate against the risk of fragmented formulations and service delivery. This will form part of an action plan following a SIRI investigation. ***(Action – see appendix B)***

8.2.43 All staff will work in collaboration with other agencies including drug and alcohol and criminal justice services to develop effective, personalised care plans. ***(Action – see appendix B)***

8.2.44 A robust system for identifying key lessons learned through the SIRI process and embedding them in clinical practice needs to be developed. Learning and action points should be focused and where possible, limited to as few as possible to mitigate against superficial action plans and dilution of action and change. ***(Action – see appendix B)***

8.2.45 The experiences of patients, family members and carers in relation to care received and suicide prevention will be sought by the Suicide Prevention Group. ***(Action – see appendix B)***

8.2.46 The Trust will ensure that all team leaders/managers have access to an up to date list of staff with the skills to provide post-incident support to staff following a suicide. ***(Action – see appendix B)***

8.2.47 Patient suicide can have a profound impact on staff personally and professionally. Line managers will identify individualised support including referring to the Work and Wellbeing Service and Occupational Health as required. ***(Action – see appendix B)***

8.2.48 Trust suicide rates will be benchmarked against other trusts nationally on an annual basis by the Suicide Prevention Group.

8.2.49 The Suicide Prevention Group will invite consultation from patients, families and carers on the implementation of this strategy. ***(Action – see appendix B)***

Systems Approaches

8.2.50 The Trust is committed to reducing high risk points in patient journeys within mental health services. Interfaces between teams and services are key high risk points for suicide where new staff teams, changes in frequency and intensity of contact and at times, re-formulation of a patient's difficulties, risk and care plan can be barriers to a seamless service experience.

8.2.51 The Trust will consider options to ensure that levels of intervention provided are equitable across the county and teams, and that they are consistent with individual needs and level of risk to mitigate against 'diagnosis and postcode' lotteries. ***(Action – see appendix B)***

8.2.52 This includes intervention from Support Time and Recovery staff who need to be able to respond quickly and flexibly to patient needs, under the supervision of professionally registered mental health practitioners.

8.2.53 Where gaps in services are identified, the Trust will highlight them to the Clinical Commissioning Group and other appropriate commissioning groups. The Suicide Prevention Group has identified the following areas where investment may contribute to suicide prevention work:

- investment in crisis teams in Somerset where funding is currently significantly below the national average;
- investment in psychiatric liaison services for the 2 district general hospitals:
- to provide increased psychiatric liaison services to the emergency departments and wards;
- to increase older people's psychiatric liaison services for people with organic mental illness. The service is not currently a seven day service;
- community-based support services for people with severe and enduring mental illness that are not time-limited;
- provision of a crisis house for when acute in-patient admissions are not indicated;
- supported housing for people with mental illness who have high support needs;

- accommodation for people with dual diagnosis who are not contemplating change in relation to their drug or alcohol problems. ***(Actions – see appendix B)***

8.2.54 The Trust will contribute to and support the multi-agency ASSIST suicide prevention training programme provided by Public Health and continue to offer training to district general hospitals and other organisations within the region. ***(Action – see appendix B)***

8.3 Area 2: Promote Mental Health and Wellbeing in the Population as a Whole

What do we know about promoting mental health and wellbeing in the population as a whole?

8.3.1 There may be a higher incidence of mental health difficulties and self-harm within some groups within the population as a whole. These groups may overlap and people may fall into more than one of these groups. Some groups may also be associated with stigma, higher levels of social and economic deprivation and experience barriers when they try to access health, social care and other resources. Groups that may fall into one or more of these categories include some people from black and minority ethnic groups and gay, lesbian and transgender groups.

8.3.2 Young people are vulnerable to suicidal thoughts and feelings and self-harm has increased significantly. Older people are another high risk group where suicide attempts are associated with higher levels of lethality.

What is the Trust's implementation plan?

8.3.3 Representatives from the Trust will sit on the countywide Suicide Prevention Advisory Group and work in partnership with Public Health and other agencies to identify approaches to promote the health and well-being of the population of Somerset. ***(Action – see appendix B)***

8.3.4 The Trust will help build individual and community resilience, promote mental health and wellbeing and challenge health inequalities and stigma where they exist, through recovery focused interventions with patients, families and carers and partnership working with Public Health. ***(Action – see appendix B)***

8.3.5 The Trust will be vigilant in monitoring accessibility to its mental health and community health services and will take action where barriers are identified. ***(Action – see appendix B)***

8.4 Area 3: Reduce Access to the Means of Suicide

What do we know about reducing access to means and suicide prevention?

8.4.1 Reducing access to high-lethality methods of suicide is one of the most effective suicide prevention measures in the general population as some people attempt suicide on impulse. Where methods are not readily

available, there may be an opportunity for intervention or suicidal ideation may be fleeting and pass.
National Confidential Inquiry reports that the methods most amenable to intervention are:

- Hanging in mental health in-patient wards and prisons:
- self-poisoning;
- suicide at high-risk locations; and
- suicide on railways and at bridges

(NCISH, 2013 a).

What is the Trust implementation plan?

8.4.2 The Trust has a Ligature Point Management Policy and the Head of Division with responsibility for inpatient mental health services, will continue to satisfy themselves that annual ligature audits are undertaken or sooner if changes are made to the environment. ***(Action – see appendix B)***

8.4.3 The NICE quality standard on 'safe prescribing' as related to reducing self-poisoning will be disseminated across the Trust. ***(Action – see appendix B)***

8.4.4 The Trust will support the Somerset Suicide Prevention Advisory Group wherever possible, in working with the Local Authority and other agencies to identify suicide hot spots and advocate for safety measures such as high fences on bridges and multi-storey car parks and signage indicating sources of help and support. ***(Action – see appendix B)***

8.5 **<u>Area 4: Provide better information and support to those bereaved or affected by suicide</u>**

What do we know about improving information and support and suicide prevention?

8.5.1 Families and friends bereaved by suicide are at increased risk of mental and emotional problems and may be at higher risk of suicide themselves.

What is the Trust implementation plan?

8.5.2 The Trust will work collaboratively with the Somerset Suicide Prevention Advisory Group to achieve its strategic aim of providing better support to people bereaved by suicide. ***(Action – see appendix B)***

8.5.3 The Trust will provide information about Somerset's Suicide Bereavement Support Service to families, carers and people in extended social networks who have been bereaved by suicide. This service provides emotional and practical support to those bereaved by suicide, including counselling and a peer support group. It is delivered through a partnership between Mind in Taunton and West Somerset, Cruise, Barnardos and the Samaritans. ***(Action – see appendix B)***

8.5.4 Reviewers undertaking SIRI investigations will involve families and carers in the investigation process in a supportive and open manner and

provide information about practical and emotional sources of help and support. All reviewers should offer families and carers the contact details for the Somerset Suicide Bereavement Support Service and the Department of Health's 'Help is at Hand' resource. ***(Action – see appendix B)***

8.6 **<u>Area 5: Support the media in delivering sensitive approaches to suicide and suicidal behaviour</u>**

What do we know about supporting the media to deliver sensitive approaches to suicide and suicidal behaviour?

8.6.1 The language used in media reports is important. Phases such as 'committed suicide' can connote criminality, blame, shame and guilt. More acceptable alternatives are 'ended life through suicide' or 'completed suicide'.

8.6.2 Media reports can be powerful particularly for vulnerable people and there is some evidence that media reports can lead to copycat suicide behaviours. Social media and websites that promote suicide and lethal methods for suicide have prompted widespread recent concern.

What is the Trust implementation plan for Area 5?

8.6.3 The Suicide Prevention Group will work with the Head of Communications to consider ways to engage with local media and encourage them to report suicide sensitively. ***(Action – see appendix B)***

8.6.4 The Suicide Prevention Group will raise awareness about the association between accessing websites and social media sites that promote suicide and lethal suicide methods and increased risk of suicide intent. ***(Action – see appendix B)***

8.6.5 The Trust's advanced risk training course for registered mental health professionals will include content on the increased risk of suicide intent where patients access social media and websites that promote suicide and lethal suicide methods. ***(Action – see appendix B)***

8.7 **<u>Area 6: Support research, data collection and monitoring</u>**

What is the Trust's implementation plan?

8.7.1 The Trust will implement recommendations wherever possible, from research and reports published by the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. ***(Action – see appendix B)***

8.7.2 Where possible, within available resources, the Trust will support and contribute to local and national research studies on suicide prevention and effective interventions. ***(Action – see appendix B)***

8.7.3 The Trust will monitor compliance with NICE guidance and quality standards through the governance structure of best practice groups which report to the Clinical and Social Care Effectiveness Group.

(Action – see appendix B)

8.7.4 The Suicide Prevention Group will benchmark Trust suicide rates against regional and national suicide rates annually. ***(Action – see appendix B)***

8.7.5 Patients, families and carers will be invited to consultation events in relation to the implementation of this strategy. ***(Action – see appendix B)***

8.7.6 The Suicide Prevention Group will monitor the action plan associated with this strategy. ***(Action – see appendix B)***

9. TRAINING REQUIREMENTS

9.1 The Trust will work towards all staff being appropriately trained in line with the organisation's Staff Mandatory Training Matrix (training needs analysis). All training courses referred to in this strategy are accessible to staff within the Learning and Development Section of the Trust Intranet. ***(Action – see appendix B)***

10. EQUALITY IMPACT ASSESSMENT

10.1 All relevant persons are required to comply with this document and must demonstrate sensitivity and competence in relation to the nine protected characteristics as defined by the Equality Act 2010. In addition, the Trust has identified Learning Disabilities as an additional tenth protected characteristic. If you, or any other groups, believe you are disadvantaged by anything contained in this document please contact the Equality and Diversity Lead who will then actively respond to the enquiry.

11. MONITORING COMPLIANCE AND EFFECTIVENESS

Process for Monitoring Compliance

11.1 This strategy will be monitored by the Suicide Prevention Group though an action plan tabled at each meeting. The group will review overall progress against the action plan annually. Quarterly reports will be submitted to the Clinical Governance Group and the SIRI Group and will include progress against the action plan. Learning from the group will be disseminated via relevant best practice groups.

12. COUNTER FRAUD

12.1 The Trust is committed to the NHS Protect Counter Fraud Policy – to reduce fraud in the NHS to a minimum, keep it at that level and put funds stolen by fraud back into patient care. Therefore, consideration has been given to the inclusion of guidance with regard to the potential for fraud and corruption to occur and what action should be taken in such circumstances during the development of this procedural document.

13. RELEVANT CARE QUALITY COMMISSION (CQC) REGISTRATION STANDARDS

13.1 Under the **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3), the fundamental standards** which inform this procedural document, are set out in the following regulations:

Regulation 9:	Person-centred care
Regulation 10:	Dignity and respect
Regulation 11:	Need for consent
Regulation 12:	Safe care and treatment
Regulation 13:	Safeguarding service users from abuse and improper treatment
Regulation 14:	Meeting nutritional and hydration needs
Regulation 15:	Premises and equipment
Regulation 16:	Receiving and acting on complaints
Regulation 17:	Good governance
Regulation 18:	Staffing
Regulation 19:	Fit and proper persons employed
Regulation 20:	Duty of candour
Regulation 20A:	Requirement as to display of performance assessments.

13.2 Under the **CQC (Registration) Regulations 2009 (Part 4)** the requirements which inform this procedural document are set out in the following regulations:

Regulation 16:	Notification of death of service user
Regulation 17:	Notification of death or unauthorised absence of a service user who is detained or liable to be detained under the Mental Health Act 1983
Regulation 18:	Notification of other incidents

13.3 Detailed guidance on meeting the requirements can be found at http://www.cqc.org.uk/sites/default/files/20150311%20Guidance%20for%20providers%20on%20meeting%20the%20regulations%20FINAL%20FOR%20PUBLISHING.pdf

14. REFERENCES, ACKNOWLEDGEMENTS AND ASSOCIATED DOCUMENTS

14.1 References

1. CQC, 2014, *Monitoring the Mental Health Act in 2012/13.* (accessed at www.cqc.org.uk).

2. Department of Health, 2014 (revised), *Statistical Update on Suicide.* London: HM Government.

3. Department of Health, Public Health Outcomes Framework for England 2013-2016

4. Department of Health, 2012 a, *Preventing Suicide in England: A Cross-Government Outcomes Strategy to Save Lives.* London: HM Government.

5. Department of Health, 2011. *No Health Without Mental Health: A cross government outcomes strategy for people of all ages.* London: HM Government.

6. HM Government, 2010, *Healthy Lives, Healthy People: Our Strategy for Public Health in England.* London: TSO

7. Department of Health,1999, *National Framework for Mental Health.* London: Department of Health.

8. Kapur, N.,2009, *Psychiatry, Suicide in the Mentally Ill, Volume 8, Issue 7, pp 257–260*

9. National Confidential Inquiry into Suicide and Homicide by People with Mental Ilness (NCISH), 2013 a, *Annual Report: England, Northern Ireland, Scotland and Wales, 2013*, Manchester: Healthcare Quality Improvement Partnership.

10. National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH), 2013 b, *Patient suicide: the impact of service changes. A UK wide study.* Manchester: University of Manchester.

11. National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH, 2013 c, *Safer mental health services: a self-assessment toolkit, (*accessed at www.bbmh.manchester.ac.uk/cmhr/research/centreforsuicideprevention/nci/toolkits).

12. NICE Guidance, 2011, *Self-harm (longer term management),* CG133, (accessed at www.nice.org.uk/CG133).

13. Office National Statistics, 2013, Statistical bulletin: Suicides in the United Kingdom

14. Somerset County Council, 2013, *Somerset Suicide Prevention Strategy 2013-2016*

15. Time to Change, 2011, *Time to Talk. Time to Change. Annual Report 2011,* Department of Health.

16. *Rabone v Pennine Care NHS Trust 2012*

14.2 Cross reference to other procedural documents

All current policies and procedures are accessible in the policy section of the public website (on the home page, click on ‘Policies and Procedures’). Trust Guidance is accessible to staff on the Trust Intranet.

Risk Management Strategy

Clinical Assessment and Management of Risk of Harm to Self and Others Policy

Ligature Point Management Policy
Serious Incidents Requiring Investigation (SIRI) Policy

15. APPENDICES

For the avoidance of any doubt the appendices in this strategic plan are to constitute part of the body of this strategy and shall be treated as such.

Appendix A Suicide Death Rates

Appendix B Trust Implementation Plan – Action Plan 2014-2017

Appendix A

Figure 1

Number of deaths and age-standardised suicide rate: by sex, country and region, England , 2011 and 2012

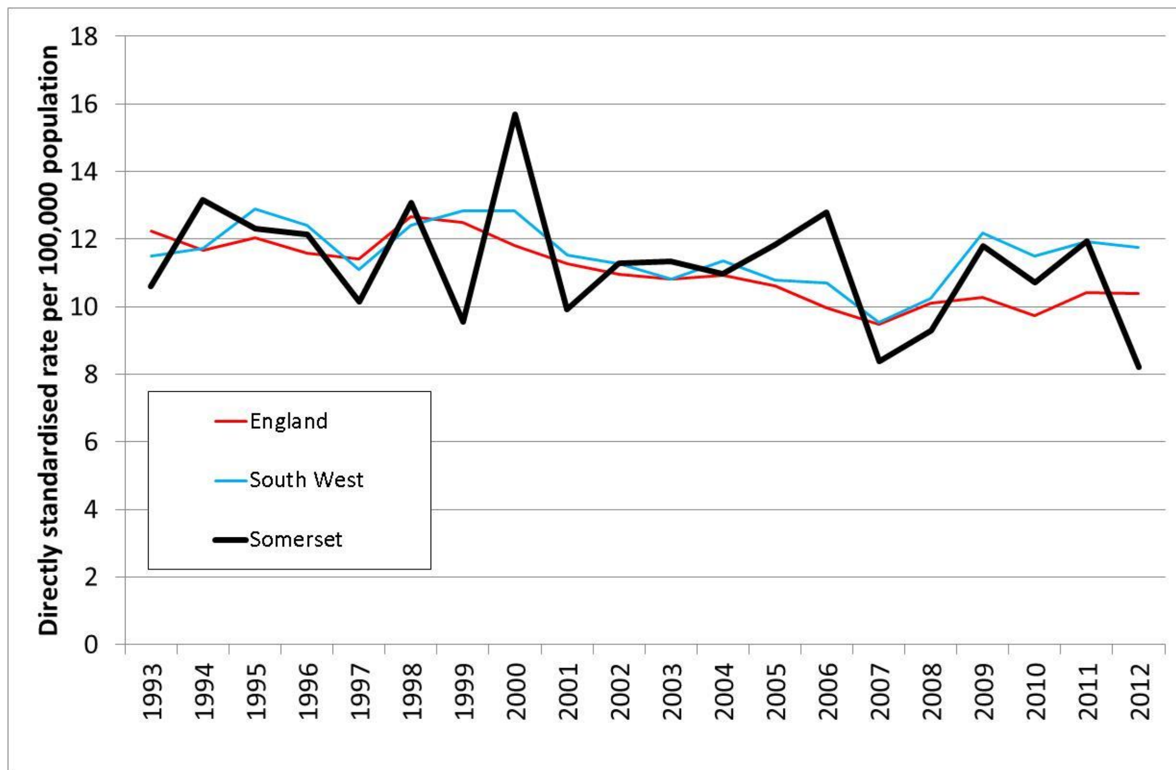
	Male			**Female**			**Persons**		
	Deaths 2012	**Rate 2012**	**Rate 2011**	**Deaths 2012**	**Rate 2012**	**Rate 2011**	**Deaths 2012**	**Rate 2012**	**Rate 2011**
England	3,483	16.4	16.1	1,024	4.5	4.9	4,507	10.4	10.4
North East	198	19.8	21.5	48	4.4	4.7	246	12.0	12.9
North West	552	19.8	18.9	152	5.2	5.0	704	12.4	11.9
Yorkshire and The Humber	381	18.2	17.0	100	4.5	4.7	481	11.3	10.8
East Midlands	302	16.5	15.6	72	3.6	4.4	374	9.9	9.9
West Midlands	357	16.3	14.4	96	4.0	4.6	453	10.1	9.4
East of England	330	14.3	15.9	110	4.4	4.8	440	9.3	10.3
South East	537	15.7	15.1	177	4.8	5.4	714	10.2	10.1
South West	392	18.1	18.6	127	5.6	5.5	519	11.8	11.9

Note: Rates are for deaths registered in 2011 and 2012 for persons aged 15 years and over, usually resident in each area based on boundaries as of August 2012.

Source: Office for National Statistics and Department of Health (2013) HSCIC information portal

Appendix A

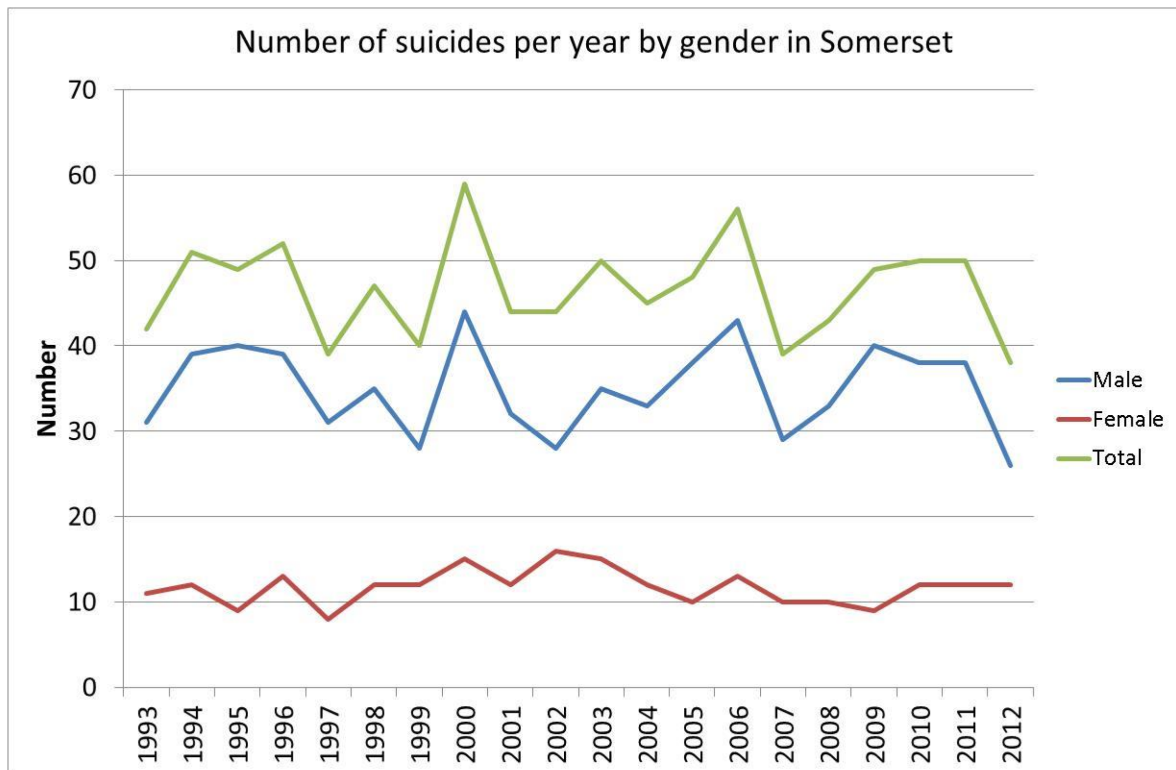
Figure 2: Directly standardised suicide rate in England and Somerset



Source: Somerset County Council (2013)

Appendix A

Figure 3: Number of suicides per year in Somerset



Somerset County Council (2013)

Figure 4: Comparison of Mortality from suicide and injury undetermined (aged15+)

Directly standardised rate per 100,000

Persons	2007	2008	2009	2010	2011	2012
England	9.48	10.11	10.28	9.75	10.42	10.40
South West	9.52	10.24	12.17	11.49	11.94	11.75
Somerset	8.38	9.30	11.81	10.72	11.93	8.21
Mendip	9.41	6.46	4.16	7.72	6.71	14.50
Sedgemoor	9.47	7.62	13.62	12.16	6.79	5.45
South Somerset	5.21	12.30	12.97	12.35	18.30	6.23
Taunton Deane	8.79	8.56	17.53	10.80	11.38	8.54
West Somerset	14.05	15.90	5.45	7.45	22.46	7.02

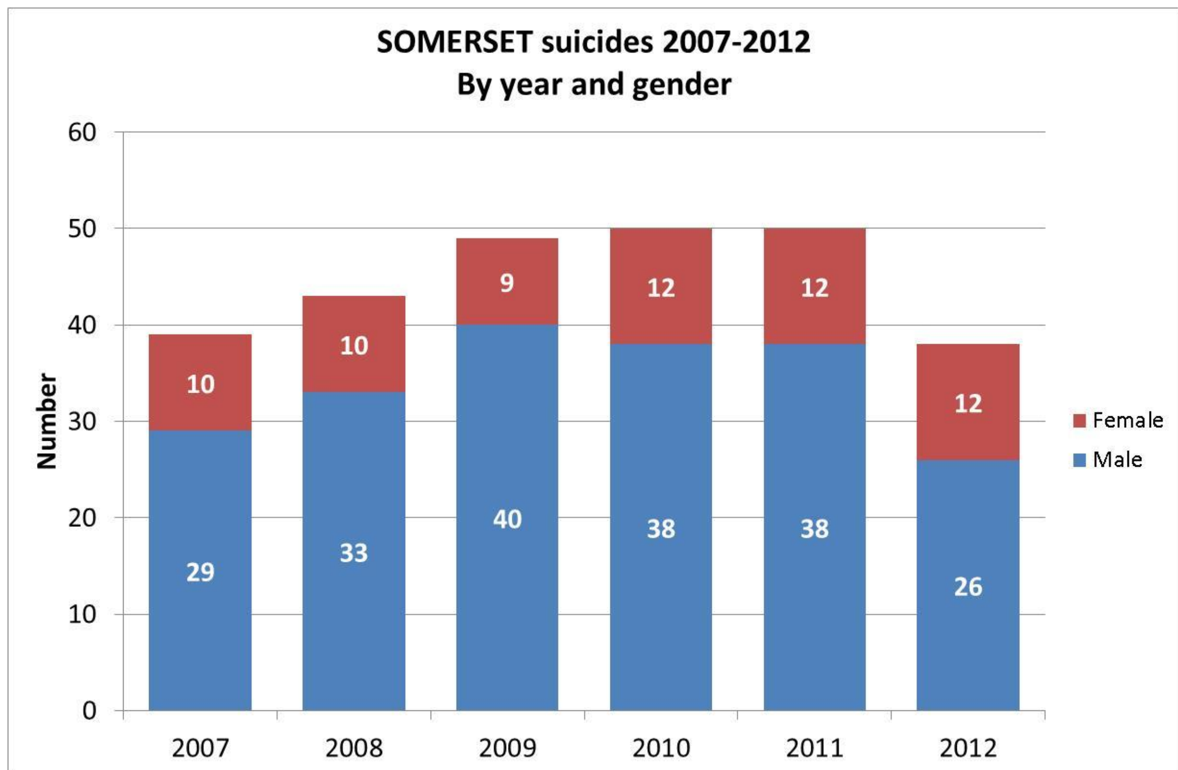
Numbers

Persons	2007	2008	2009	2010	2011	2012
England	3,988	4,275	4,379	4,193	4,509	4,507
South West	416	441	514	494	516	519
Somerset	39	43	49	50	50	38
Mendip	7	8	3	9	6	14
Sedgemoor	9	9	12	14	6	5
South Somerset	8	16	16	16	22	10
Taunton Deane	9	7	16	9	11	8
West Somerset	6	3	2	2	5	1

Somerset County Council (2013)

Appendix A

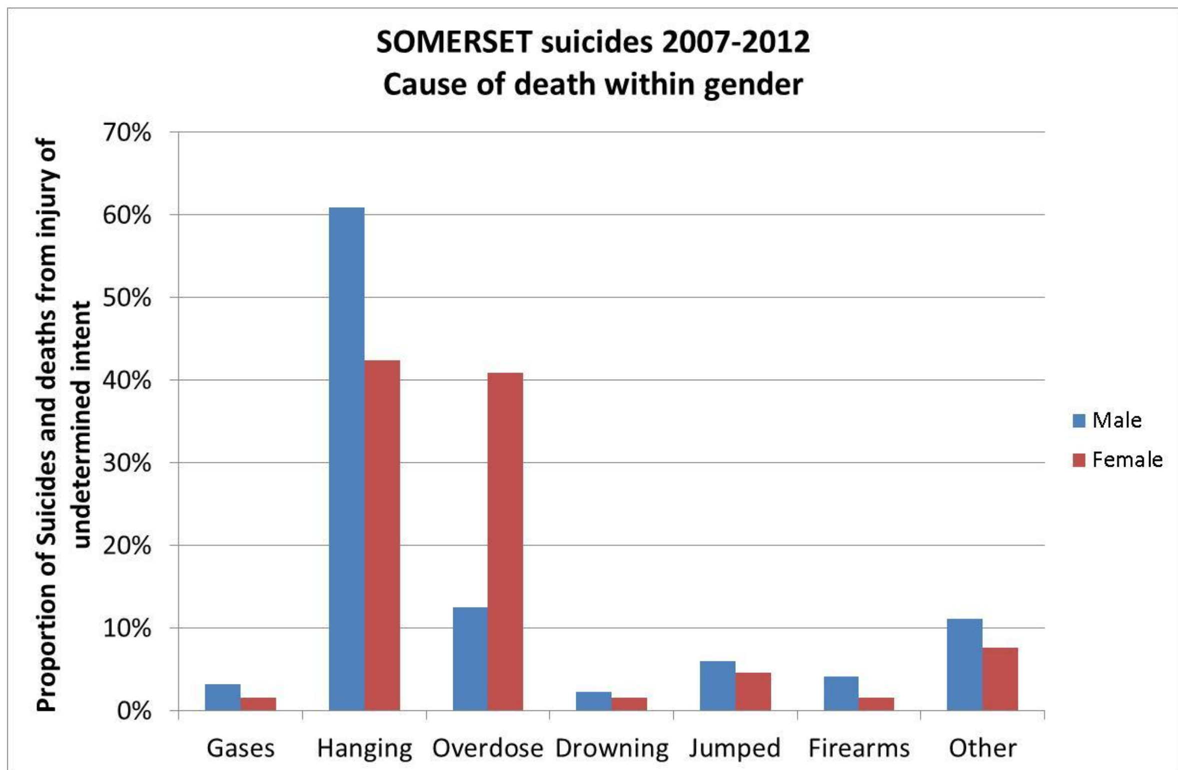
Figure 5: Comparison of suicide *numbers* by gender



Somerset County Council (2013)

Appendix A

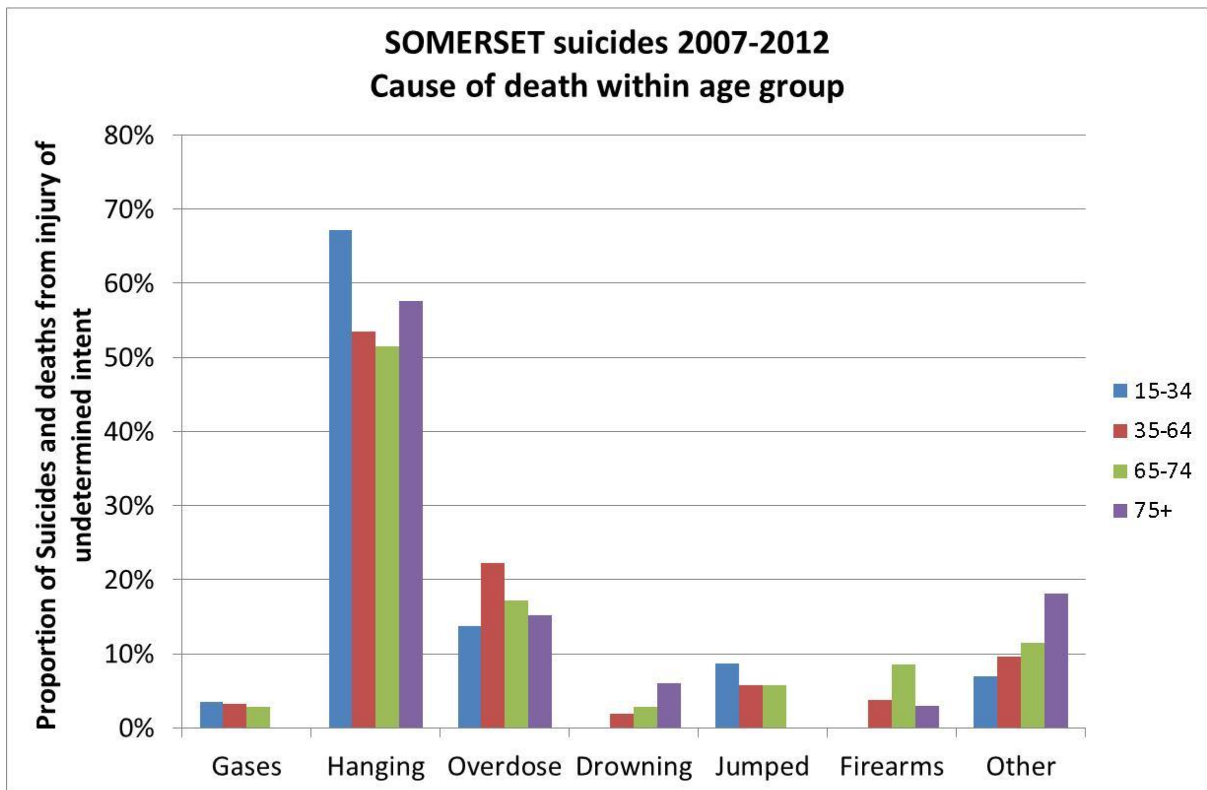
Figure 6: Cause of death by gender



Somerset County Council (2013)

Appendix A

Figure 7: Cause of death by age group



Somerset County Council (2013)

Appendix B

TRUST IMPLEMENTATION PLAN
Action Plan 2014 - 2017

Action		X Ref to Strategy
Area 1: Reduce the Risk of Suicide in High Risk Groups		
To advocate for increased funding for the Crisis Teams from the CCG in order to extend current service to 24 hours.		8.2.12
To continue to monitor follow up within seven days of discharge from in-patient care via divisional dashboards.		8.2.13
For SIRI reviewers to facilitate a reflective multi-disciplinary review with relevant teams following a suicide or suspected suicide.		8.2.15
To add a section on managing non-compliance with medication into the Medicines Policy.		8.2.16
To develop a new policy, or incorporate into an existing policy, guidance for the management of patients who refuse treatment and for the RCPA Group to consider strengthening practice guidance in relation to DNAs and disengagement from services.		8.2.17
To continue to monitor compliance/implementation of relevant NICE guidance relevant to suicide prevention at Trust level and seek assurance at service/team levels via mental health Best Practice Groups. Relevant NICE guidance includes guidance on schizophrenia, self harm and depression.		8.2.18
To develop training for front-line mental health staff in the assessment and management of self-harm in line with NICE guidance.		8.2.20
For professionally qualified mental health staff working across all age groups to attend the advanced risk training course every three years or be signed off as competent by line managers. Compliance		8.2.21

will be monitored via mandatory training reports.		
Adapted risk assessment and management training courses will be delivered for Talking Therapies staff and appropriate staff groups from community health teams.		8.2.22
The Trust will continue working with NHS South of England to complete the following in-patient work streams that have been adapted and extended from the South West Quality and Patient Safety Improvement Programme for Mental Health: 1. AWOL questionnaire to be rolled out across in-patient wards; 2. Patient feedback to be gathered Trust wide in relation to do patients feel included in decisions about their care; 3. Resource directories to be developed for patients, families and carers for all wards; 4. Photographic identification to be implemented in all in-patient wards		8.2.24 8.2.28 8.2.29 8.2.30 8.2.32
Improved safety measures for medicines reconciliation on admission and discharge are to be developed for all in-patient wards.		8.2.31
To consider rolling out the use of the SBAR tool across mental health services in the Trust.		8.2.33
To roll out relevant work streams from the Patient Safety Improvement Programme into community teams.		8.2.34
To implement the ‘Safer mental health services: a self assessment toolkit’.		8.2.35
To consider the development of a Suicide Prevention and Self-Harm Care Pathway.		8.2.36
To explore opportunities to improve formulation based psycho-social assessments as recommended by NICE.		8.2.37
To continue to provide evidence based psychological therapies.		8.2.39
To explore extending service provision for people following suicide attempts.		8.2.40
To continue to provide a complex care review panel to support teams and practitioners with care planning and decision making.		8.2.41
A complex care management system is required for high risk, very complex cases where multiple Trust services and other		8.2.42

organisations are involved.		
All staff to work in collaboration with other agencies, such as drug and alcohol and criminal justice services to develop effective care plans. Methodology to assess compliance will need to be developed.		8.2.43
A robust system needs to be developed for identifying key lessons learned through the SIRI process and embedding them into clinical practice.		8.2.44
The Suicide Prevention Group will collate the experiences of patients, family members and carers in relation to care received and suicide prevention.		8.2.45
All team leaders/managers have access to an up to date list of staff with the skills to provide post-incident support to staff following a suicide.		8.2.46
Line managers to identify individualised support for staff following a suicide; methodology to assess compliance will be developed.		8.2.47
The Suicide Prevention Group will invite consultation from patients, families and carers on the implementation of this strategy.		8.2.49
Levels of intervention provided should be equitable across the county and teams, and consistent with individual needs and level of risk to mitigate against 'diagnosis and postcode' lotteries.		8.2.50
Gaps in service provision relating to suicide prevention will be highlighted to the CCG.		8.2.53
Area 2: Promote Mental Health and Wellbeing in the Population as a whole		
To continue to contribute to and support the ASSIST suicide prevention training programme and to continue to offer training to other organisations.		8.2.54
Representatives from the Trust to continue to sit on the countywide Suicide Prevention Advisory Group and to work in partnership with public health and other agencies.		8.3.3
To help build individual and community resilience, promote mental health and wellbeing and challenge health inequalities and stigma where they exist through recovery focused interventions and collaborative work with Public Health via the Suicide Prevention		8.3.4

Advisory Group.		
To monitor accessibility to the Trust's mental health and community health services and take action where barriers are identified.		8.3.5
Area 3: Reduce access to the means of suicide		
The responsible Head of Division will continue to monitor annual ligature audits.		8.4.2
The NICE quality standard on 'safe prescribing' to be disseminated across the Trust.		8.4.3
The Trust will support and collaborate with the Somerset Suicide Prevention Advisory Group wherever possible.		8.4.4
Area 4: Provide better information and support to those bereaved or affected by suicide		
The Trust will work with the Somerset Suicide Prevention Advisory Group to achieve its' strategic aim of providing better support to people bereaved by suicide.		8.5.2
The Trust will provide information about Somerset's Suicide Bereavement Support Service to people bereaved by suicide.		8.5.3
Reviewers undertaking SIRI investigations will involve families and carers in the process in an open manner.		8.5.4
Area 5: Support the media in delivering sensitive approaches to suicide and suicidal behaviour		
The Suicide Prevention Group will work with the Head of Communications to consider ways to engage with local media to encourage sensitive reporting.		8.6.3
Awareness will be raised about the association between accessing websites that promote suicide and increased risk of completed suicide.		8.6.4
The Trust's advanced risk training course for mental health professionals will include content on the increased risk of suicide associated with accessing websites that promote suicide.		8.6.5
Area 6: Support research, data collection and monitoring		
The Trust will implement recommendations from research and reports published by the National Confidential Inquiry into Suicide		8.7.1

and Homicide by People with Mental Illness.		
Where possible, the Trust will support and contribute to local and national research studies on suicide prevention.		8.7.2
The Trust will monitor compliance with NICE guidance and quality standards.		8.7.3
The Suicide Prevention Group will benchmark Trust suicide rates.		8.7.4
Patients, families and carers will be invited to consultation events in relation to the implementation of this strategy.		8.7.5
The Suicide Prevention Group will monitor the implementation of this action plan.		8.7.6