Norfolk and Suffolk NHS
NHS Foundation Trust

Suicide Prevention Strategy

2013-2015

"We will provide high quality, safe care to reduce the likelihood of an individual taking their own life."

your wellbeing in mind

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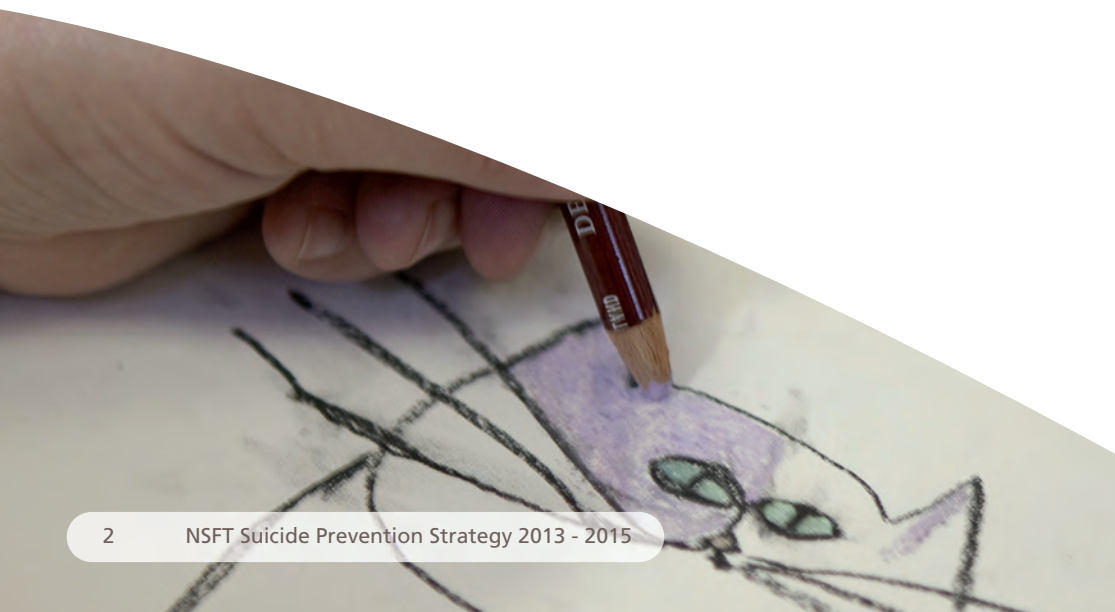


Roz Brooks
Director of Nursing
Patient Safety and Quality

Introduction

I present this **Suicide Prevention Strategy** for Norfolk and Suffolk NHS Foundation Trust (NSFT) for the period 2013 to 2015. This strategy sets out how, through the delivery of safe and effective care, the Trust will attempt to reduce the likelihood of incidents of suicide by people using its services.

Suicide is a devastating event. A loss of life is an individual tragedy felt most directly by family and friends. Although the number of people taking their own lives has reduced in recent years, there were still 5,608 suicides in the United Kingdom in 2010. Every mental health service has a duty to ensure that deaths amongst its service users are prevented wherever possible, even though suicide accounts for a minority of overall deaths. As an example, there has been a national fall in suicides whilst people are in hospital directly linked with the removal of rigid curtain rails and ligature points.

Norfolk and Suffolk NHS Foundation Trust provides services, for a wide range of people in many settings, both in primary and secondary care and often in partnership with other organisations. These include the Wellbeing Service, Acute Mental Health and Recovery Services, Child and Adolescent Services, Learning Disability Services, Alcohol and Drug Services and Forensic Services. The Trust is in a position to make a significant contribution in preventing suicide. The Trust's challenge is to ensure that patient safety and quality of care underpins every action.

How is this to be achieved? Clearly it means that people at risk of suicide should receive timely intervention with robust pathways of care. The Trust must provide staff with the training

and skills to assess people at potential risk and manage them safely. There must be robust processes in place to review and learn from incidents of unexpected death. Of critical importance, it means working with our service users and their families and carers.

The Department of Health updated its strategy in 2012 ***Preventing Suicide in England.*** The Trust is committed to adopting the strategy's recommendations.

'patient safety and quality are key to ensuring that our services reduce the likelihood of an individual taking their own life.'

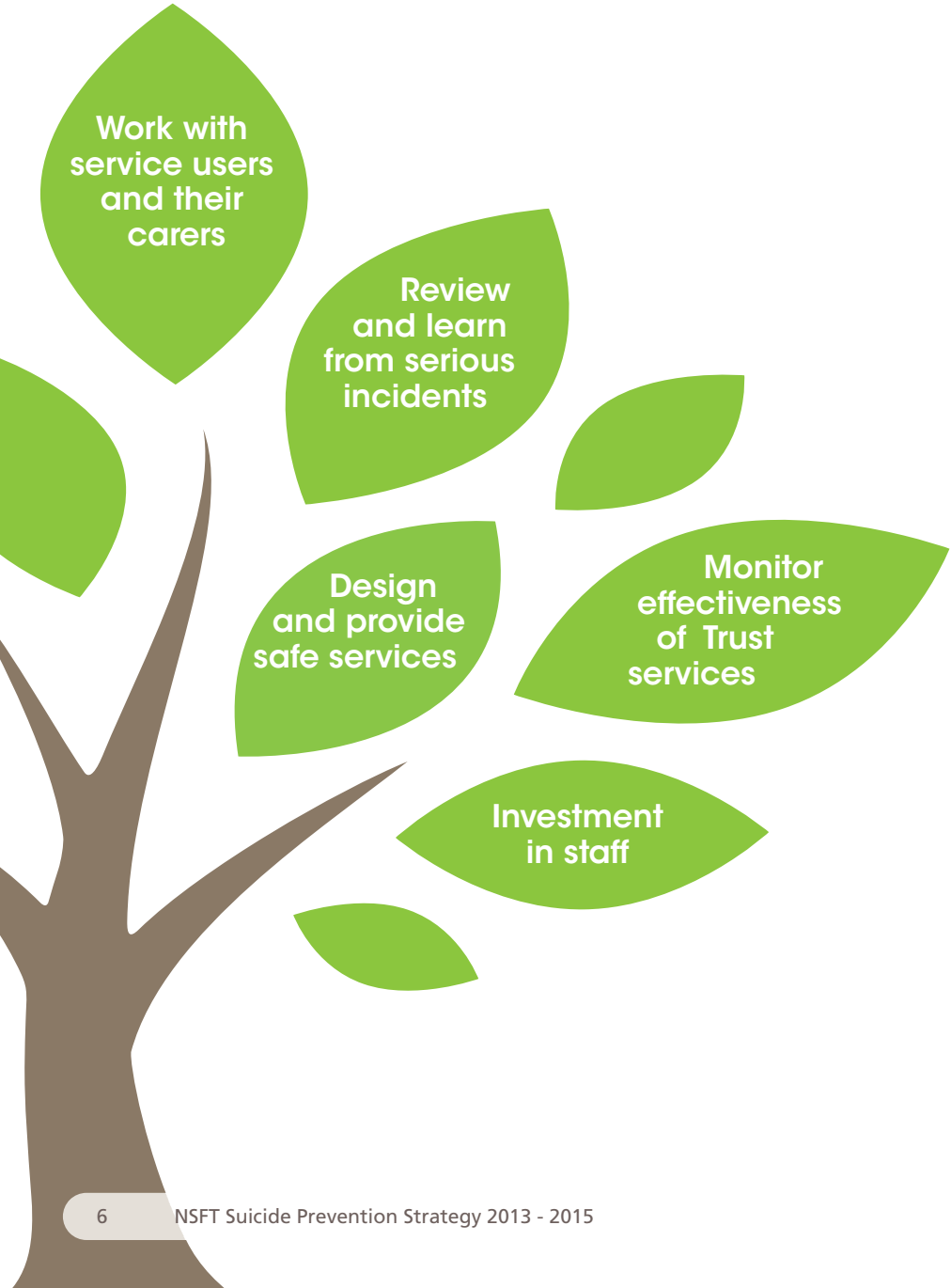
Roz Brooks.
Director of Nursing, Patient Safety and Quality.

'Our pledge'

Norfolk and Suffolk NHS Foundation Trust believes that providing safe and effective services will help to reduce the likelihood of an individual taking their own life.

This reflects our commitment to providing person centred expert care, resulting in the best possible outcomes and experience for everyone who uses our services.

What will we do?



Work with service users and their carers

Partnership with service users and their carers is central to the Trust's purpose. Safe and quality services cannot be delivered without their engagement. This extends to their involvement in the design, delivery and monitoring of our services.

The Trust will:

- **Listen to individual service users, their families and carers.**

  Listening to individual service users and their families with care and skill is an essential ingredient of all safe mental health practice and care. Its central importance to suicide prevention will be reflected in all training of our clinical staff.

- **Support the integral role of the Trust's Service User and Carer stakeholder groups.**

  Support for these groups will ensure that Trust services are designed and applied which place the service user and their support at the heart of all interventions. The Trust will involve them, for example, in reviews of Trust policies on suicide risk assessment and management as well as staff training.

- **Implement the Trust's Service User and Carers strategy.**

  These strategies support the Trust's commitment to ensuring service users and carers experience a high quality service.

- **Implement the principles of *Being Open*, guidance which promotes the sharing of information regarding an individual's care following serious incidents.**

  The Trust's clinical and management staff will work closely with service users and their families in an open, honest and transparent way, consistent with principles set out in *'Being Open'* published by the *National Patient Safety Agency (NPSA)*.

Investment in staff

The Trust will ensure our staff have the skills to assess effectively and safely manage those people who are at risk of suicide.

The Trust will:

- **Provide training on how to assess risk.**

  Providing staff with the skills and knowledge to assess risk is one of the foundations for delivery of high quality and safe patient care. The Trust's commitment to systematic training on suicide risk assessment will emphasise the importance of listening to service user and carer / family alongside careful observation. Reliable assessment tools will be used to record risk with an emphasis on regular review. Training will take account of differing clinical contexts (e.g. children and young people, older adults, those with substance misuse) and the place where the assessment takes place (e.g. A&E department, inpatient ward, police station, community). The Trust will monitor individual compliance with this training.

- **Provide training on management of risk.**

  When current or possible future suicide risk is identified, in whatever setting, staff need to implement evidence-based management strategies designed to reduce or prevent suicide. Trust training programmes for clinical staff must incorporate those policies known to be effective in reducing suicide risk across different settings. These can range from enhanced Observation Policies in inpatient areas to enhanced community support such as home treatment or monitoring by family members / carers. Targeted training will cover management strategies appropriate to particular conditions and groups. Individual compliance with designated training programmes will be monitored by the Trust.

Provide time for clinical supervision, enabling staff to reflect and develop their practice.

Clinical staff develop their skills and improve practice, with benefits to service users if given the opportunity to reflect systematically on their experiences in clinical supervision. The Trust is committed to the development and expansion of clinical supervision in the workplace for all multidisciplinary professionals. This is a powerful mechanism for promoting best practice and should reduce suicides amongst our service users. The Trust already recognises the importance of supervision in improving the quality of written records covering suicide risk and its management.

Design and provide safe services

The Trust will design services that provide timely and effective support for people who are at risk of suicide.

The Trust will:

- **Work with partner organisations.**

  Service users at risk of suicide must never ***'fall between stools'*** where their management relies on a range of agencies or services. The Trust is committed to robust partnerships with other organisations that consistently address service user safety. This may involve sharing information about individual service user risk and the strategy in place to reduce suicide risk.

- **Design services and pathways of care with service user experience and safety at its core.**

  Implementing programmes such as ***Improving Recovery through Organisational Change (ImR0C),*** wellbeing strategies and early interventions provides the foundations for best practice provision of care.

- **Ensure that the environments are safe e.g. reducing ligature risks.**

  Many environmental features that may increase suicide risk are known. Particular national focus has been on ligature points in hospitals. The Trust has invested heavily in remedying the latter in the recent past. It will remain vigilant to this risk and to other risks as evidence (national and local) becomes available. The Trust seeks to provide environments that minimise the risk of harm to service users.

Monitor effectiveness of Trust services

The Trust will monitor the effectiveness of its services as part of its assurance that safe high quality care is being provided.

The Trust will:

- **Audit compliance with those policies most relevant to people at risk of suicide e.g. Risk Assessment; Observation and Engagement with Service Users; Care Programme Approach.**

  The process of audit looks to provide assurance that services are implementing the policies and protocols the Trust has prescribed.

- **Use the *National Patient Safety Agency's* audit toolkits.**

  Systematic audit of practice, on applying the above named and other relevant tools, conducted in different clinical services, should provide assurance that Trust policies and protocols are being followed. Training and other resources can be targeted to those areas where weakness is identified. Repeat audits are essential.

  The Trust will review policies and service developments relevant to suicide prevention in light of new evidence on best practice. Its audit programme must adapt to such changes and allow the Trust to review the effectiveness of its policies in due course, as part of its assurance programme.

- **Development and use of audit in response to new evidence linking with service development and policy review.**

  The Trust will review policies and service developments relevant to suicide prevention in light of new evidence on best practice. Its audit programme must adapt to such changes and allow the Trust to review the effectiveness of its policies in due course, as part of its assurance programme.

Review and learn from incidents

The Trust will monitor all incidents involving possible suicide risk to enable detection of any trends with a bearing on patient safety in this area.

The Trust will:

- **Apply the *Serious Incidents Requiring Investigation Policy* to ensure serious incidents are reviewed and all possible learning implemented.**

  The Trust continues to be committed to reviewing serious incidents in line with national guidance, implementing learning.

  The Trust promptly reviews serious incidents in line with national guidance, following an established protocol. These reviews are conducted by clinicians independent of those treating the service user and are reported to the ***Trust Service Governance sub Committee*** and ***Trust Board***. Family members are informed of these reviews and their outcome, as is HM Coroner.

- **Monitor key indicators of suicide risk such as self harm and absconding, addressing trends as they arise.**

  The Trust is committed to reviewing incidents, identifying interventions and learning.

How will this suicide prevention strategy be monitored?

In order to demonstrate effective commitment and compliance with this strategy, the Trust must monitor progress at regular intervals. Most Trust clinical governance issues are routinely monitored or reported through the ***Service Governance sub Committee.*** This committee will receive six monthly updates covering such key areas as:

- **Training -** Clinical Risk Assessment and Management, Suicide Prevention
- **Audit -** of Risk Assessment / Risk Management / observation policies
- **Environmental issues -** e.g. ligature points
- **Serious incident reviews -** including actions / recommendations

Updates will be shared with the Trust's Service User and Carer Stakeholder groups and the Governors Performance and Scrutiny Committee. Public updates will be published on an annual basis.

Conclusion

Prevention of suicide is a central goal for all mental health providers, including NSFT. There is no single approach to reducing the likelihood of an individual committing suicide. A cohesive, varied combination of actions is generally required to support the Trust's service users during those periods where they are most vulnerable.

This strategy sets out the approach taken by NSFT to the prevention of suicide whilst providing care for its service users. It encompasses established best practice and evidence supporting the delivery of safe and effective care.

Acknowledgments

Grateful thanks to all the staff, governors and partners who contributed to the development of this strategy.

A special mention to the graphics team for their hard work and commitment to making the launch of the strategy come to life.

References and resources

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Norfolk and Suffolk NHS Foundation Trust values and celebrates the diversity of all the communities we serve. We are fully committed to ensuring that all people have equality of opportunity to access our service, irrespective of their age, gender, ethnicity, race, disability, religion or belief, sexual orientation, marital or civil partnership or social and economic status.

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