BRIEFING DETAILS	
Subject	SUICIDE PREVENTION ANNUAL REPORT
Report Author	Debbie Wint, Suicide Prevention Lead
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BRIEFING

Introduction

This report sets out the position for suicide prevention across SFT and provides an annual briefing to the Quality and Governance Committee.

Suicide rates in Somerset have been high in recent years compared to national data, with an increase in 2018 and 2019 to 99 coroner confirmed deaths by suicide in each of the years, 2018 and 2019. In general, smaller numbers of deaths in Somerset compared to other areas and regions can mean an annual comparison rate for Somerset is subject to volatility and so a longer term trend approach is detailed below.

In contrast to a predicted surge in the number of suicides due to COVID-19 impacts which had been widely reported in the national media, rates of suspected suicide in Somerset during 2020 were lower when compared to the two previous years. This is consistent with national data which appears to show a reduction in suicides during lockdowns.

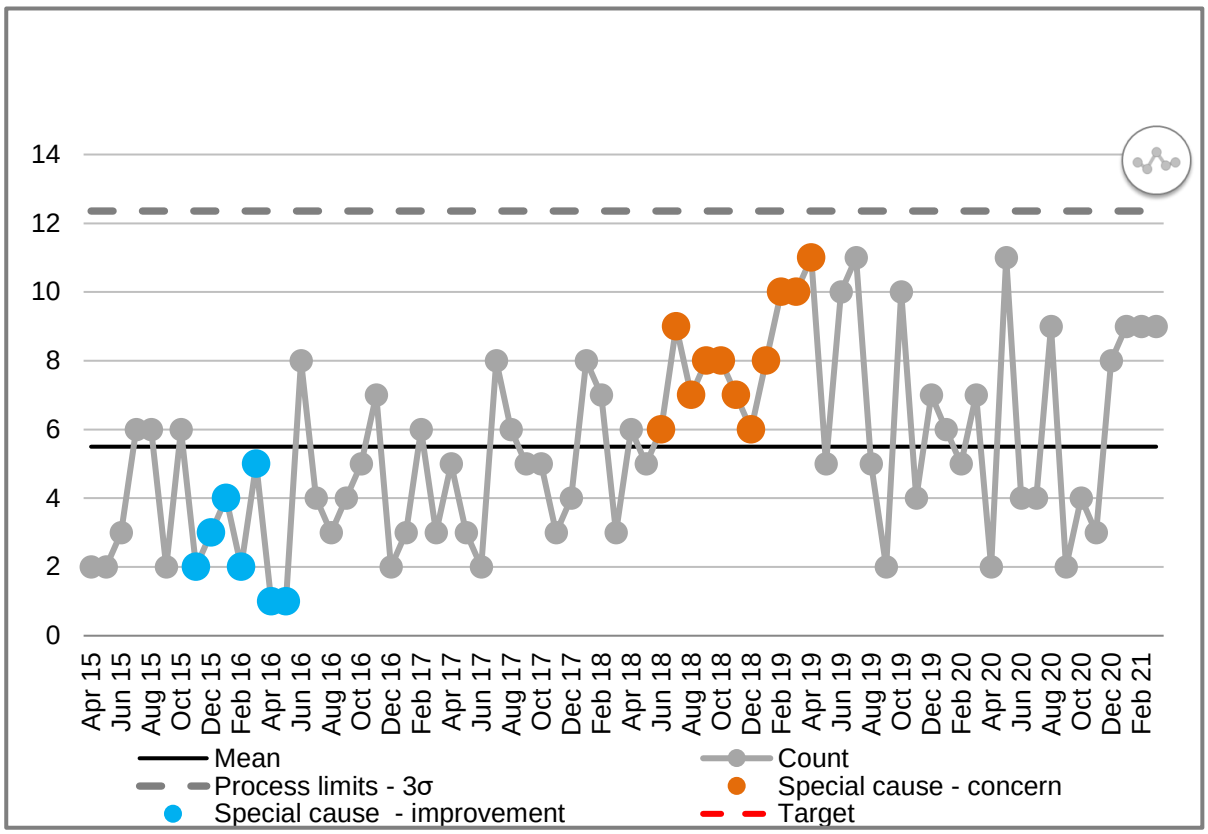
Somerset suspected suicides

Figure 1. overleaf provides trend data from PHE using is a Statistical Process Control chart, and plots monthly total suspected suicide deaths in Somerset since April 2015 and identifies statistically significant changes in data.

The dotted lines (process limits) represent the expected range for data points if variation is within expected (normal) limits. In the graph orange dots signal that more than 7 sequential points fall above the central solid line (mean) and is considered ‘unusual’ and may be an indicator of a significant change in process, where the process is not in control. Whereas blue dots indicate 7 or more sequential points falling below the mean line, it is a special cause indicator of improvement.

Suspected suicide figures must be viewed with caution and sensitivity as these data are subject to change following the coroner’s hearing.

Figure 1. Somerset countywide suspected suicides (monthly) from 01/04/15



Nationally, 27% of deaths by suicide are people under the care of secondary mental health services (National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH)). In Somerset, the rate for people being seen in mental health services varies between 25% and 50%. In 2020, 43% of those recorded as suspected suicides were recorded as having been known to mental health services in the previous 12 months.

Local figures collated by Public Health (Fig. 1) for suspected suicides include deaths of people who have had attendances at primary care mental health services such as Talking therapies, while NCISH data only includes secondary mental health services. Higher rates of contact with Somerset mental health services maybe a positive indicator of improved access to services through, for example, the Mindline 24 hour helpline and Open Mental Health.

Wider impacts on suicide rates

A recent NCISH study into the deaths of middle-aged men emphasised the impact of wider determinants of suicide. These included isolation, loneliness, substance misuse and comorbid physical health conditions. Nationally, 52% of middle aged men who died in 2017 had chronic physical health conditions including circulatory, respiratory, digestive conditions and chronic pain. These issues are considered locally as part of our suicide review processes and have led to the identification of comorbid chronic pain as a recurring theme in mental health suicide death investigations.

Drug and alcohol use

Substance misuse not only increases the risk of suicide but also correlates with a number of poor mental and physical health outcomes.

Nationally, a minority of patients who died by suicide between 2008 and 2018 were in contact with specialist substance misuse services, despite alcohol and drug misuse being a common antecedent of patient suicide in all UK countries (58% of all patient suicides UK-wide, higher in Scotland and Northern Ireland).

Across the United Kingdom, alcohol related hospital admissions have increased by 130% over the past decade. Despite having a relatively affluent catchment population which are typically associated with

lower rates of alcohol related admission, the situation in Somerset[1] is significantly worse than the national average which places a burden on acute services due to people requiring hospital admissions.

In England, there was a 25% fall in rates of suicide by patients in those NHS Trusts with a policy on the management of patients with comorbid alcohol and drug misuse (NCISH).

It is for these reasons that we emphasise that suicide is everybody's business and not just the domain of mental health services.

An SFT substance misuse strategy proposal is in development which it is hoped will be an important factor in the range of measures to support reducing suicide. This strategy would enhance and improve responses across the service to encourage access to substance misuse interventions, including a critical outreach function for those who are struggling to engage.

Somerset countywide strategy

The Somerset countywide strategy is managed through the Suicide Prevention Partnership Board (SPPB) which is the multi-agency forum that leads this work locally for Somerset. The group is responsible for the delivery of the overall Somerset Suicide Prevention Strategy and Action Plan.

In support of the countywide strategy, PHE also chair a Suspected Suicide Case Audit & Oversight Group. This examines data to highlight patterns, concerns and trends for suspected and actual suicides. This group shares information to inform SPPB, such as highlighting high-risk geographical areas such as bridges where clusters may have occurred. Subgroups of the board liaise with organisations such as network rail, highways agency, and police to implement measures to reduce risk where possible.

The Trust has representatives from the Mental health and Learning Disability directorate who attend the Somerset Suicide Prevention Partnership Board and the Somerset Suspected Suicide Case Audit & Oversight Group.

Somerset Foundation Trust

The Mental health and Learning Disabilities Serious Incident Review Group (SIRG) is held every 2 weeks to investigate and explore learning from all serious incidents including suspected suicide deaths which occurred within 6 months of contact with the service. MH/LD SIRG covers all CAMHS, adult and older people mental health inpatient and outpatient services. Learning identified in SIRG gives feedback into the directorates and to the mortality surveillance group (MSG)for oversight and assurance around unexpected deaths. MSG asks directorates to evidence learning and for this to be presented at their bimonthly meeting.

A governance briefing with information about recommendations has recently been developed by the MH/LD directorate to share learning more widely beyond those teams involved. Examples in the first edition included changes to the way pregnant women are admitted to mental health wards. In response to a 72 hour incident review of a recent death and following a briefing to the Executive team, en-suite doors in Holford PICU, as well as in Willow and Ash wards were removed to reduce ligature point availability, and currently options for safer alternatives are being considered. A full SI investigation is being undertaken.

A quarterly Suicide Prevention Group (SPG) is attended by representatives from MH/LD, CAMHS, PLT, inpatient mental health services and Older peoples Mental Health. The primary focus of this group is to improve practice and outcomes in mental health services. This group also oversees the suicide prevention audit, supports the management of emerging issues and identifies strategic priorities.

[1] According to PHE (2018) approximately 20% of the Somerset population aged 16 years and over drink at a level which damages their health. Despite having a relatively affluent catchment population, which are typically associated with lower rates of alcohol related admission, the trust has higher alcohol related admissions than national average. Estimates suggest that alcohol-related healthcare costs in Somerset, including physical and mental health, equate to about £67 per adult annually
Alcohol Change report (2018) https://s3.eu-west-2.amazonaws.com/files.alcoholchange.org.uk/images/AC-Lauch-report-online.pdf
Public Health Observatory, Local Alcohol Profiles for England: http://www.lape.org.uk/natind.html
https://fingertips.phe.org.uk/profile/liver-disease

Examples of this include making the recommendation to ensure all patients discharged from mental health units are reviewed within 48 hours, based on evidence that the highest risk for suicide post discharge is within the first 2-3 days. .

Dr Dan Meron, Chief Medical Officer, has been identified as the Executive Lead for Suicide Prevention.

In 2021, the MH/LD directorate established funding for the 2 year secondment of a 0.9 WTE suicide prevention clinical lead, and a 2PA medical suicide prevention lead but these roles do not have a Trust wide remit. These lead posts were filled in Spring/Summer 2021. The primary focus of these roles in year one and year two is upon improving practice within our mental health and learning disability services and learning from local and national evidence and intelligence. This is a new initiative for SFT, however it is noted that other neighbouring mental health trusts have significantly more resources to address the suicide prevention agenda.

Funding was also agreed for the recruitment for 4 part time suicide prevention peer recovery and wellbeing workers in Open Mental Health. These colleagues are undergoing training as part of the HEE peer support training initiative. Their roles include working with people with non-crisis presentations who have recently been struggling with suicidal thoughts, and help to them access interventions within the Somerset Mental Health services and the wider network.

A suicide prevention audit was last completed in 2019. This was a comprehensive audit into many potential factors which may contribute to suicide risk. The audit in 2019 led, for example, to recommendations for increase in family and carer involvement in care which has led to an ongoing quality improvement project. The suicide prevention leads are currently working to ensure that the audit standards are aligned with the National Confidential Inquiry into Suicide and Homicide (NCISH) Toolkit for Safer Services for specialist mental health services and primary care. This 'toolkit' is based on evidence from the past 20 years of research into patient safety and the areas for greatest impact are illustrated overleaf (see fig. 2).

Figure 2. Ten key elements identified by NCISH for safer care for patients

Mental health services

In 2020, during the early months of the pandemic there was a significant expansion of mental health provision in Somerset including the extension of the Mindline telephone support helpline to a 24/7

service, and the establishment of Open Mental Health. This is a partnership of NHS and VCSE providers, including Mindline, as well as the Crisis safe space, which is a bookable crisis support service run by Mind and Second step, and available across localities in Somerset.

Mental health services overall in Somerset received 527 referrals per 100,000 population in 2019/20 [national average 407] and increased to 602 per 100,00 in August 2021 [national average 382] (NHS Benchmarking Network, Covid-19 Monthly Tracker, Mental Health, Learning Disability & Autism Services, August 2021).

Overall, referrals to Somerset mental health services saw an increase during the pandemic. The following graphs (figures 3, 4 & 5) illustrate referral rates across HTT, PLT and CMHTs. These new services have resulted in some 3800 contacts a month being offered by Open Mental Health, 350 appointments being available in Crisis safe space, as well as the capacity for 41 patients to be supported by the Next Steps service supporting people on discharge from mental health inpatients.

Figure 3. Home Treatment Team referrals by month

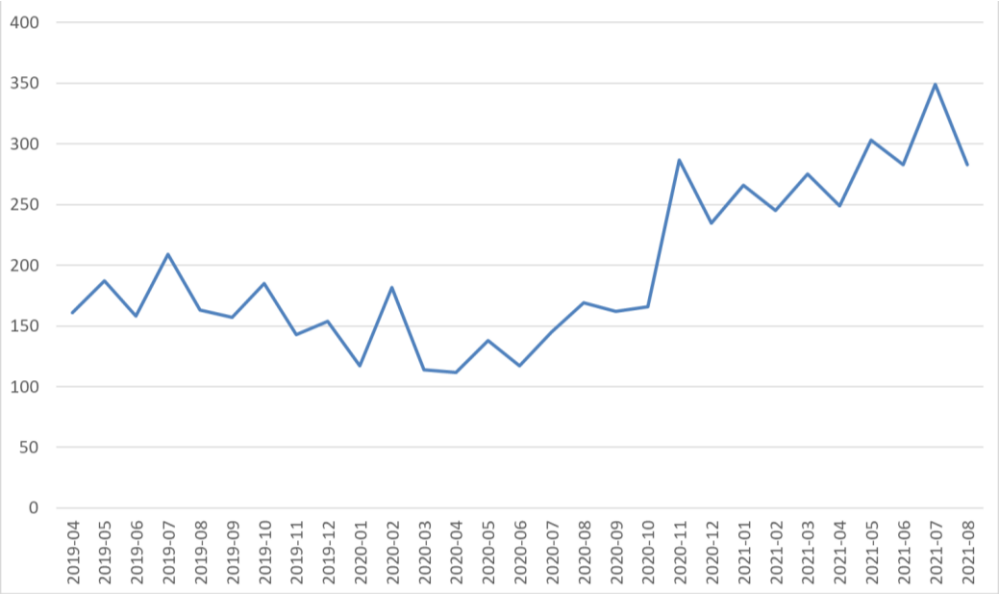


Figure 4. MPH Psychiatric Liaison Service referrals by month

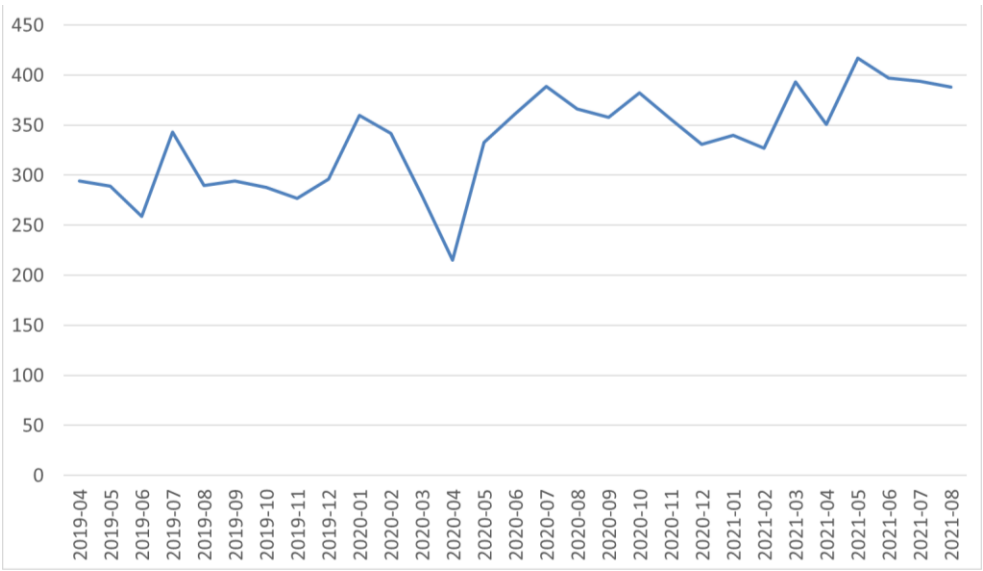
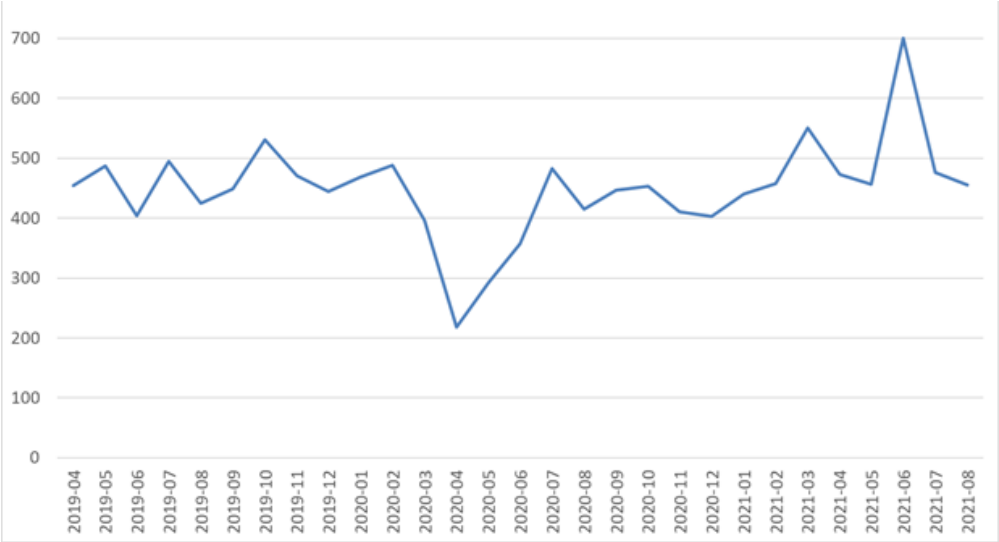


Figure 5. Community Mental Health Team referrals by month



Recurring themes

Key and recurring themes collated by the SPG and SIRG have led to corresponding initiatives within the directorate. These include three QI projects; on Families and Carers, improving carer recording in Rio, and embedding learning from deaths by suicide, as well as supporting the development of the SFT substance misuse strategy, and ensuring aligning and linking the suicide prevention and dual diagnosis strategies.

Information for referrers

Following feedback from professionals in SFT, the information for families, carers and professionals on the SFT public facing website 'mental health in a crisis' page[2] has been updated with improved information about local support services and referral pathways, as well as resources for carers or people who are worried about someone.

This webpage also directs visitors to the UK's first 24/7 text service, free on all major mobile networks, for anyone in crisis anytime, anywhere, 'SHOUT' will work to find ways to help access the support already in place as well as other forms of support that may be needed including contacting emergency services or social services if needed[3].

Wider Somerset Foundation Trust system

As an integrated physical and mental health trust moving toward merger with YDH, there is a great opportunity to support wider suicide prevention initiatives, beyond those in mental health to reach people at risk of suicide, including those with comorbid physical health conditions and substance misuse.

Staff support

The Trust employs colleagues from groups who have an elevated risk of suicide and unfortunately there are colleagues within the Trust suspected to have died by suicide. During 2020 the Colleague Support Service was expanded to provide a comprehensive 7 day telephone support line and an assessment and intervention service for colleagues in need of support and this team have adapted their practices to manage suicide risk including using safety planning, and have developed clear lines of referral with our existing mental health services.

[2] https://www.somersetft.nhs.uk/help-in-a-crisis/mental-health-crisis8/
[3] https://giveusashout.org/

World suicide prevention day 2021

The annual World Suicide Prevention day on 10 September 2021 included a presentation at the Chief Executive's Team Briefing to emphasise that suicide prevention is everybody's business, not just the domain of mental health services. The campaign included a blog summarising suicide awareness information and resources which was circulated in Staff news and shared on the SFT public facing website.

In collaboration with the Colleague Support Service, a video on safety planning was developed and shared for colleagues, and a video addressing feelings of loss for staff bereaved by suicide was made by the lead chaplain for community and mental health.

A social media campaign was led by the communications team. A 'Hands of Hope' campaign invited colleagues to share words, phrases or messages that give hope, as well as messages for others and pledges of action also led in collaboration with the communications team, Colleague Support Service and with the suicide prevention leads. The materials from the Hands of Hope campaign will be ued to develop posters for key areas in the Trust including acute wards and departments with signposting to local support services.

Debbie Wint also provided a radio interview to BBC Somerset with other agencies including Mindline and the Somerset Suicide Bereavement Support Service. Other projects included a podcast with Somerset Emotional Wellbeing and a presentation to the recent online Somerset Emotional Wellbeing conference.

Staff training

There is a significant interest and demand for suicide prevention training in key staff groups including research nurses, staff at inpatient wards where patients are admitted after suicide attempts, as well as district nurses, paediatric inpatients, PALs, complaints, and other colleagues and teams.

CPD funding has been identified for suicide prevention and awareness training for registrants across SFT working in non-mental health settings during 2021/22. Potential training providers have been identified and a training proposal is being discussed at the Learning Committee.

RECOMMENDATIONS

Mental health services

Suicide prevention falls within the remit of all staff providing mental health interventions, and as such overlaps with a range of ongoing initiatives such as the recent revision of the clinical risk assessment training, depression audit and the care plan audit.

During years one and two, the seconded Suicide Prevention leads will continue to focus on improving family and carer contact with the service, involving families more with learning from incidents, supporting the development of a SFT substance misuse strategy and dual diagnosis interventions and oversee an audit of practice of prescribing in depressive disorders.

They will also work with the SPG to align the Trust's Suicide Prevention Audit which was last completed in 2019 with the NCISH Safer Services Toolkit audit and carry out a new audit in 2022.

The leads will also focus on expanding suicide prevention training and learning events within mental health services to complement and enhance suicide prevention assessment and intervention skills to meet national competency frameworks for suicide and self-harm as well as embedding learning from incidents using QI approaches.

SFT wide

To continue to encourage the uptake of the free zero suicide alliance online training which takes 15 minutes and focusses on building confidence and skills to help people who may be considering suicide.

This training is important in moving toward breaking the stigma around suicide, and encouraging people to have open conversations about their mental health. Although not mandatory, this short training has been promoted widely across Somerset in particular through PHE and the countywide SPPB, and the feedback from colleagues in SFT that have completed the training has been very positive.

The committee are asked to note and support the expansion of Suicide Prevention awareness training for SFT staff working in non-mental health settings, to increase awareness of potential risk factors and interventions. CPD monies have been identified and a proposal currently sits with the Learning Committee. It would be important to support this work important across YDH as the new merger develops.

To consider how to develop suicide and serious incidents postvention[4] leadership and strategy which would include supporting those staff experiencing bereavement due to death by suicide of a patient, colleague or loved one, and outlining managers procedures for responding to a death by suicide either or a patient or a colleague

[4] Postvention is an organised response following a suicide with the aim to: 1. Facilitate the healing of individuals from the grief and distress of suicide loss, 2. Mitigate other negative effects of exposure to suicide, and; 3. Prevent suicide among people who are themselves at high risk after exposure to suicide.