Cumbria Partnership NHS
NHS Foundation Trust

Annual Report for CPFT Suicide Prevention Plan

2015 - 2016

Happier | Healthier | Hopeful

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1. Executive Summary

1.1 The paper aims to describe the activity to support the CPFT suicide prevention plan and to provide an update on improvement activities during 2015/16 and Q1 and Q2 2016/17.

The CPFT Suicide Prevention Plan was launched in November 2013. This plan is considered to be still relevant and well thought through, however, it was recognised that greater investment in terms of resources was required in order to have the desired effect and impact of suicide prevention at the frontline.

This paper provides details of the organisational structure to deliver the strategy, action taken at the frontline and from central services. The paper is organised into three distinct sections with the introduction providing a background to the national and local context. The next section describes the work being undertaken at the frontline (in care groups and networks in CPFT). The final section provides an overview of the work largely co-ordinated by central services. However, it is important to note that most work activity on suicide prevention is interlinked between central and frontline services so clear distinctions are not possible.

2. Introduction – context setting

2.1 National and local data on suicides

The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (2015) based on figures between 2003-2013 show in the general population the lowest suicide rates are in London and the south-east, with higher rates in the north and south-west. The highest increase is most marked in the general population in men aged 45-54 in England (37% increase since 2006). There is an even larger increase in the number of male patient suicides since 2006 (73%). This figure is based on numbers rather than rates and the number of patients overall has risen. The drivers for this increase are the following risk factors; a) alcohol and b) economic pressures. It may also be due to an increase in use of hanging, which is an especially dangerous method.

Along with other areas in Northwest England (11.5), Cumbria has a higher rate of suicides in the general population than the England national average (10.0) (Office for National Statistics, 2014). With the exception of Allerdale, all the local authorities have a higher rate than the England average as shown in the table below:

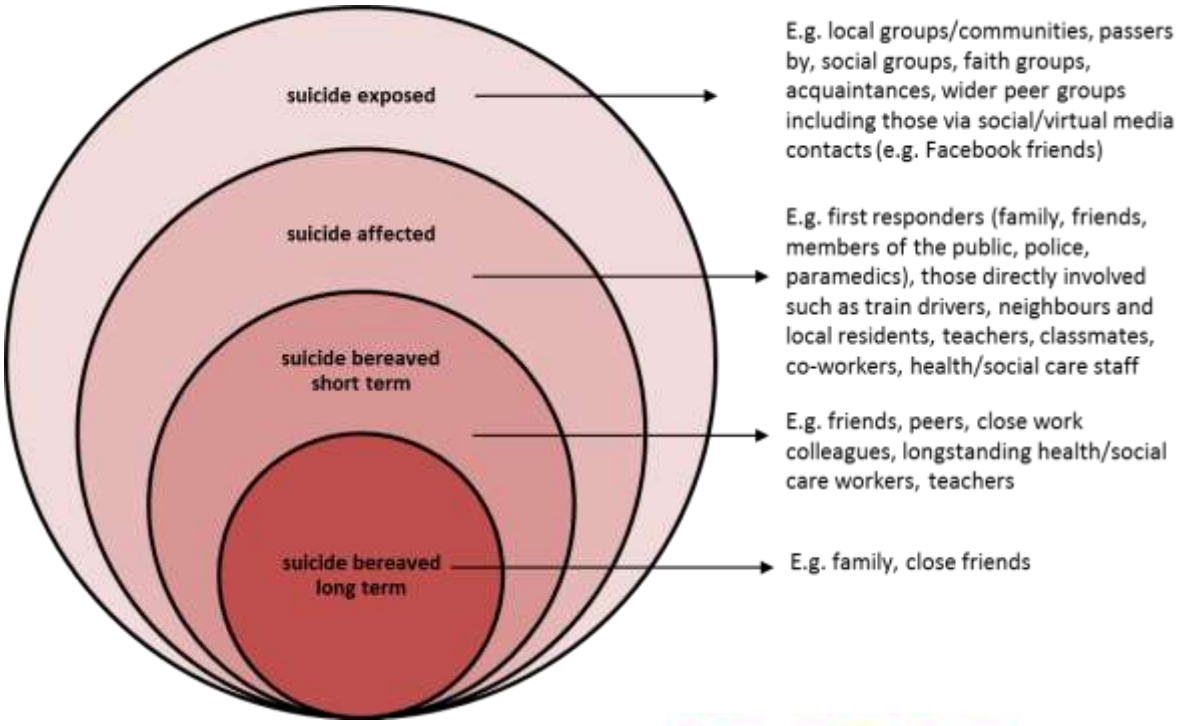
Table 1: Number of deaths and age-standardised suicide rates for local authorities, rolling three year aggregates, deaths registered 2012-14. The figures presented are for persons aged over 10 years of age (Office for National Statistics, 2014).

Local Authority	**Suicide rate** (2012-14, rolling 3 year aggregate)	**Number of people who have died from suicide** (2012-14, rolling 3 year aggregate)
Allerdale	8.8	22
Barrow-in-Furness	11.9	22
Carlisle	11.3	32
Copeland	16.1	30
Eden	11.3	15
South Lakes	15.9	44

2.2 The ripple effect of suicide

Suicide is statistically rare but is devastating for those involved from the individual to family, a wide range of those around them and also professionals involved.

Diagram 1 below illustrates the ripple effect of a suicide.



There is increasing recognition for the needs of these individuals and groups to be considered and supported following a suicide. Preventing suicide where possible and improving post suicide support remain priorities in CPFT. The two logic diagrams below show the overarching CPFT suicide prevention plan, including activities, participants and outcomes. The second logic diagram presents current and future actions for post suicide support across the Cumbria wide system;

INPUTS	OUTPUTS		OUTCOME		
	Activities	Participation	Short	Medium	Long

Preventing people dying prematurely from suicide

SITUATION	WHAT WE INVEST	WHAT WE DO	WHO WE REACH	SHORT TERM	MEDIUM TERM	ULTIMATE IMPACT
Suicide is statistically rare but devastating for those involved from the individual to family, a wide range of those around them and also professionals involved. Preventing suicide wherever possible and supporting all of those is therefore a priority for CPFT in partnership with others as is effectively understanding and learning from each tragic event where these do occur. Within CPFT we have had well thought through corporate suicide prevention plans that have not had the effect at the frontline we would have wished and therefore we acknowledge the need for a focussed and distributed approach. We have diverse services including mental health, children's, community and specialist services which gives us more opportunity to prevent suicide in these areas as long as the focus is relevant and bespoke to each of these areas rather than 'one size fits all' There is local and National evidence to guide us.	The active and positive partnerships and knowledge across the system including the public health led leadership group Senior Leadership time A 2 year band 7 post and potentially some communication time from an Intern A proactive trust wide move to a learning culture to support this work within the trust and across boundaries Support from CLIC, AQuA, NENC AHSN, NCISH Support from leadership of our care groups and networks including Quality and Safety leads to prioritise time within our clinical governance systems and as their Quality Improvement projects Time and support from 'critical friends' who give us their time and attention to improve our plans.	**Connect with partners via the Cumbria Suicide Prevention Leadership Group** **Create an infrastructure within the CPFT to support projects:** Bespoke and evidence based suicide prevention plans through the service The communications project (awareness, engagement, attitude survey) • Training and awareness • Real time alerts to prevent suicide in crisis care • Staff support • Post suicide intervention • Thematic reviews of SIRIs and Oxford learning events • Risk management Project **Link to other relevant QI projects:** • Improving learning lessons, SIRIs and RCA • Learning across boundaries • Learning cultures • Duty of Candour	Those who are struggling with suicidal thoughts and actions Their families and friends The staff of all organisations who support them Those touched by loss by suicide The leadership groups who commit to this work together	We have a structure and resources to support our work. We have a communications framework that raises general awareness and engages our staff and external stakeholders We have the first drafts of bespoke team prevention plans and the NCISH event to support their development in evidence base We have continued to improve the 'safe' culture of learning across the trust and with partners. We have built the train the trainer capacity in the trust We have an improved ability to work across systems to identify possible suicide early and learn lessons from suicide and near misses including the real time alerts project	Each clinical tam has a suicide prevention plan that is well known and used by staff. These include working with partners such as other teams and providers, families and carers There is audit and other methods that evidence progress against the plan. We have an event with NCISH where they act as 'critical friends' to improve these further We are progressing staff training Support for those touched by suicide including staff is becoming systematic and there is a capacity/ demand review carried out across the system with commissioners There is a learning culture, systems and processes across the system post suicide. There is a reduction in themes that have been identified before from SIRIs	**There are high levels of competence and in frontline staff to prevent suicide with a good level of evidence based knowledge (national and local) to support this.** **That there is evidence of a high level of inclusive and appropriate safety planning across all of our services to prevent suicide** **That where there is a suicide appropriate support and intervention is available with partners for all involved who require this.** **That there are continuous learning systems in place for CPFT and contributions across the system for near miss and suicide.**

Assumptions

- That adoption of systematic and evidence based models and best practice will reduce suicides
- That there is continued commitment to partnership working for suicide prevention
- That there will be a venue to reflect on the commissioning implications of gaps in services

INPUTS	OUTPUTS		OUTCOME		
	Activities	Participation	Short	Medium	Long

Post suicide support model for Cumbria

SITUATION	WHAT WE INVEST	WHAT WE DO	WHO WE REACH	SHORT TERM	MEDIUM TERM	ULTIMATE IMPACT
Supporting those bereaved by suicide is a key element of both the National Suicide Prevention Strategy and the Cumbria Suicide Prevention Strategy. Suicide can have a devastating impact on individuals, families, communities, and professionals. There is no one organisation in contact with all those who are bereaved or who need support There is currently no systematic approach to post suicide intervention in Cumbria. There are however patches of good practice and a commitment to work together. There is growing evidence and practice for locally developed and delivered support	There is an established leadership group with skills. Social capital and a commitment to spend shared time on this collectively. There are resources and skills in the system: • SOBS • Community awareness and support projects • Bereavement support services • Mental health and IAPT where appropriate There are initiatives that further these efforts – such as Duty of Candour in NHS organisations that will contribute to open and honest supportive conversations	Ensure consistent early outreach from: Police, Coroner/Coroner officer, and NHS Primary Care. By providing information on grief and bereavement by suicide and signposting to a range of support sources: Help is at Hand. Self help support groups such SOBS, Cruse, Samaritans . One to one support – provided by qualified practitioners and trained facilitators, or by mental health service (CAMHS/IAPT) and qualified practitioners. Coroners Courts Support Service (CCSS) – emotional and practical support to families and other witnesses attending inquests . Audit and assess current demand and capacity and where there may be a commissioning need	Family and close friends (suicide bereaved long time**).** Friends, peers, close work colleagues, longstanding health/social care workers (suicide bereaved short term). First responders (family, friends, police, paramedics, members of the public), those directly involved such as train drivers, neighbours and local residents, teachers, classmates, co-workers, health/social care staff (suicide affected). Local groups/communities, passers by, social groups, faith groups, acquaintances, wider peer groups such as those via social/virtual contacts (suicide exposed).	Offer outreach immediately after **each** suicide as first contact is important (SOBS Cumbria evaluation). . Include in the Cumbria 'Form 38 Sudden Death Report' a prompt for police officers BTP to signpost those bereaved/ affected to 'Help is at Hand' resource and other sources of support. Congruent model (eg using *Help is at Hand)* model with mental health carers strate Provide individuals with a choice over what service to access and when (clear overview of what is available). Coroner Court Support Service – signpost to bereavement support during and following inques	Support the mental health and wellbeing of bereaved individuals. Increase community menta health awareness and improving individual and community resilience (reducing stigma) Feedback and evaluation from those bereaved by suicide to enable improvement and clarificat of resource available.	**A systematic approach to post suicide intervention in Cumbria resulting in effective and timely support for those bereaved or affected by suicide.** **A culture of working together to provide this, of understanding the impact it is having and continuously improving the system including the identification of gaps and resource need.**

Assumptions

- Locally delivered support programmes rely on strong partnerships between commissioners, experienced providers, coroners, police, and local services and there is the assumption that these will continue to grow and be prioritised.
- Bereavement process is different for everybody (SOBS Cumbria evaluation) and therefore choice and diverse approaches will be supported including for example the needs of different needs of adults and children, of those facing additional challenges, and cultural issues.
- That this improvement project sits in a range of other suicide prevention including learning lessons, reviews (including child death, drug related deaths and safeguarding) and actions from these, community and awareness projects and specific staff support.

2.3 Governance/ Leadership Arrangements in CPFT

2.3.1 Preventing suicide wherever possible and supporting all of those involved has therefore been recognised as a key priority for CPFT along with the need to work alongside other agencies in the Cumbria system to be as effective as possible. These agencies include the police, Unity, Public Health and Survivors of Bereavement from Suicide (SOBS), Cumbria Acute hospitals, Samaritans and MIND. Effectively understanding and learning from each tragic event where these do occur is also an essential component to preventing further suicides.

2.3.2 The suicide prevention plan in CPFT is now driven by a structure of groups, support networks and links. CPFT has invested in senior leadership time centrally and in individual care groups and networks along with a two year fixed term band 7 post.

2.3.3 There are regular meetings for each of the groups in the diagram to steer, analyse and feedback activity and these are described below;

2.3.4 The membership of the core group includes the Associate Medical Director for Quality, the Associate Director of Nursing (Mental Health), Head of Clinical Governance and the Suicide Prevention Project Lead. This group meets monthly to review progress on the overall plan, decide how best to influence the implementation of the goals and objectives and scope and identify new opportunities to improve suicide prevention in CPFT.

2.3.5 The steering group acts as a critical friend to the overall plan and proposals. The membership is therefore designed to offer different perspectives and therefore includes representation from non-statutory services carer's and SOBs besides heads of departments and clinical leadership from the care groups.

2.3.6 The operations meeting and group is an opportunity for frontline services in all care groups to provide feedback on their suicide prevention plans and share practice. The overall suicide prevention plan and information from interlinking meetings is also included.

2.3.7 There are task and finish groups which have been set up to provide further focus on particular themes; development of real time alerts, improving risk formulation and supporting staff following a suicide. The task and finish groups for real time alerts and supporting staff following a suicide will be discussed in detail in the next section of this report. Improving risk formulation is specific to the mental health group and has reviewed, improved the risk screening and assessment tool the Galataen Risk and Safety tool (GRiST) and developed training in risk assessment for frontline staff in mental health.

2.3.8 The Suicide Prevention Leadership group meetings are chaired by Cumbria Public Health. Representation is from statutory and non-statutory which play a key role in suicide prevention in Cumbria. These key functions include;

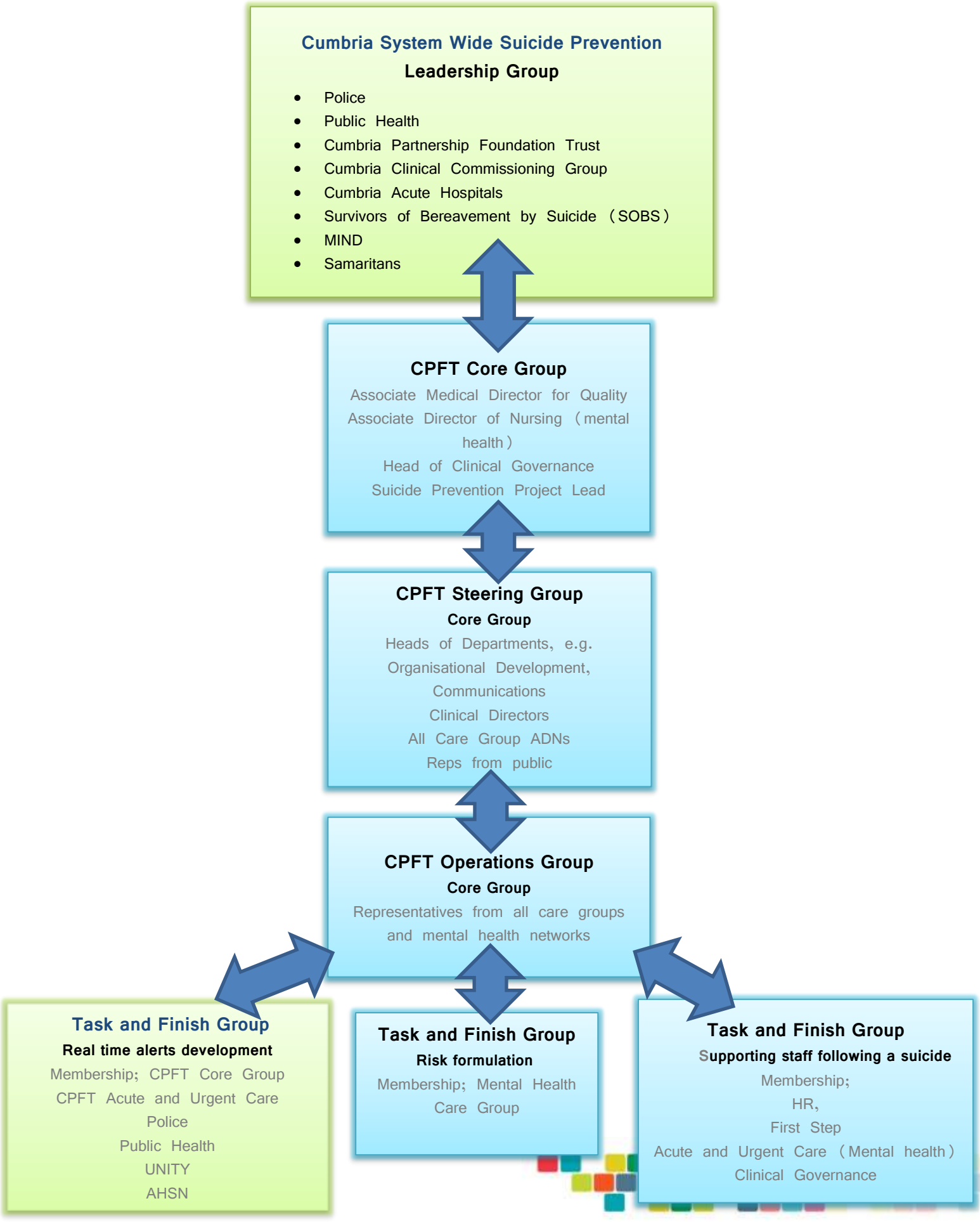
- To monitor the implementation and impact of the Cumbria Suicide Prevention Strategy and Action Plan and review annually.
- To report to the Cumbria Health and Wellbeing Board via the Cumbria Public Health Alliance.
- To connect with, and share learning and collaborate with, the Cumbria Local Safeguarding Children Board, Cumbria Safeguarding Adults Board, Cumbria Mental Health Partnership Group, Cumbria Mental Health Crisis Care. Concordat, Cumbria Emotional Wellbeing and Mental Health of Children and Young People Board, and other multi-agency and single agency governance bodies as appropriate.
- To highlight and share local, national and international intelligence, good practice and research related to suicide and its prevention, and in relation to people impacted by suicide.
- To recommend further work to reduce suicides in Cumbria as appropriate.

2.3.9 Active and positive partnerships and knowledge across the systems play a significant part in supporting these structures and actions. For example, there is support for projects from CLIC, AQuA, North East/North Cumbria Academic Health Science Network (NENCAHSN).

2.3.10 In addition there are governance and work stream meetings in individual care groups and networks where suicide prevention is the focus or on the agenda. For example, the Acute and Urgent Care network have recently help an away day where their local suicide prevention plan was reviewed and structures put in place to improve links across CPFT.

2.3.11 Diagram 2 on the next page describes the structure of the suicide prevention groups in CPFT and the wider system in Cumbria.

Structure of suicide prevention groups



3. Suicide prevention at the frontline

3.1 This next section in this paper will describe the activities undertaken by the care groups and networks in CPFT.

3.2 All population groups may experience a suicide and therefore all four care groups play a role in suicide prevention. The diverse services CPFT delivers reaches into a wide range of population groups. This gives more opportunity to prevent suicide in these areas as long as the focus is relevant and bespoke to each of these areas rather than 'one size fits all' approach. National guidance, such as the National Confidential Inquiry into Suicide and Homicide (2015) and for children and young people (2016) has also been used to influence the plans along with the findings from incidents and Serious Incidents Requiring Investigation (SIRI).

3.3 In line with the recognition and evidence base that change is most effective when led from the frontline all care groups agreed to and are provided with support to develop their own local suicide prevention plan. The table below provides a review of all the care groups. Below the table is an example of a suicide prevention plan (developed by First Step).

Table 2: **Suicide prevention priorities of care groups and networks**

Mental Health Care Group Suicide Prevention Priorities	
First Step	Dave Sandford, Senior Psychotherapist and Richard Thwaites, Clinical Director have driven the following areas of work in First Step; ▪ Improving support for staff involved in the care of a patient who dies from suicide, leaflet and face to face support. The motivation to complete this work arose from concerns regarding staff distress when a patient dies from suicide. The knowledge and expertise from this work is now being applied across the organisation via the work in the task and finish group; Improving support for staff following a suicide. ▪ Training and embedding the Integrated Motivational-Volitional Model of Suicidal Behaviour (IMV model) into everyday practice to help increase understanding of the psychology of the suicidal mind. https://sites.google.com/site/suicidalbehaviourresearchlab/the-imv ▪ Funding a staff member to take a PHD with the above research department ▪ A continuous cycle of audit for risk formulation (third cycle due to commence December, 2016) to measure and embed improvement. This approach has been successful in

	improving understanding of risk formulation and the tools used across First Step. ▪ Development of risk champions in frontline teams to promote and support best practice in risk formulation. ▪ Participation in STORM training delivery ▪ Dave Sandford has received funding and is currently completing a PHD in relation to exploring the impact of suicide on members of staff and considering how staff can be supported went a traumatic incident occurred For a full overview of objectives and actions see driver diagram on page 18.
Acute and Urgent Care Network	The two distinct services in this network (inpatient and crisis and home treatment) have developed individual plans. Team leads (Barbara Slater and Jill Archibald) have been nominated to lead the work supported closely by the Clinical Director and Network Managers. A recent away day provided an opportunity to refocus on the plan and work more closely with the Quality and Safety Lead and Suicide Prevention Project Lead to support aligning goals and actions between the frontline, wider care group and central services. Crisis and home treatment priorities; ▪ Improved evaluation of risk via better engagement with patient and family –evidence base from NCISH key finding; *"Families and carers are an under used resource and staff told us closer contact with patient's families in their view could have reduced risk"* ▪ Reducing incidents where communication issues are a theme (links with future project on relational co-ordination) ▪ Development of out of hours single point of access service ▪ 2 hour response to A&E with a dedicated liaison team within core business hours ▪ STORM training delivery and attendance ▪ Being key stakeholders in the real time alerts project The inpatient priorities are; ▪ Reduce the number of suicides within 28 days of discharge by improved discharge arrangements ▪ Sharing the plan with the frontline ▪ Spreading across all inpatients tested, innovative practice, such as the allocated carer/relative dedicated time developed on Hadrian ward. As discussed above this links with the key message from NCISH (2015) Jill Archibald will provide further information about the work in a video.
Community Mental Health and Recovery	The CMHART have identified that increasing training in risk formulation is their initial priority. Staff in this network are also involved in the delivery of the STORM

Teams (CMHART)	training. The survey on staff attitudes towards suicide prevention has resulted in improved staff engagement in this group, including a plan to undertake a medically led audit of suicides in the south of Cumbria.
Memory and Later Life	Memory and Later Life network have developed their strategy based on national guidance from the National Council on Aging (2012) 'Preventing Suicide in Older Adults'. This paper argues that to be effective, a strategy must work on different levels: universal, selective and indicated. The strategy in Memory and Later Life reflects this. In relation to indicated the review by the group of the literature relating to homicide/suicide in older people alongside the findings from a Domestic Homicide Review involving older people in Cumbria meant this work had particularly resonance for the staff in this care group. The network has formed a specific group, has formed a strategy, completed an evaluation of risk training and is due to carry out an audit. In undertaking this work the network has found there is currently a weak evidence base nationally for suicide prevention in older people. Opportunities to gain external funding (through the AHSN) to support the work in this care group are currently been explored. The development of this strategy has enabled the group to realise the potential to make a real impact on their population group by: - Aligning their work better with other key groups, Community nurses, for example and Primary Care to support earlier identification of depression and suicide/homicide risk - Reducing risk of suicide by improved identification and care of those individuals who do not present with signs and symptoms which are usually associated with suicidality. For example, subtle deterioration in self-care and self-help in an older person, particularly, if over a long period can be attributed to physical health problems by others. As mentioned above the findings from the review on homicide/suicide has led to an increased understanding of characteristics which the network are now in an improved position to undertake further work on
Quality and safety in mental health care group	The Mental health care group has developed the PRISP model (outline shown below) to provide a clear framework to guide quality and safety work in close the learning loop. This has been presented by a Senior Quality and Safety Lead, Kath McGleenan at a national event. PRISP • Prevent – avoidable harm • Reflect – when harm occurs

- Improve – Based on lessons learnt
- Share – learning widely
- Prevent –future harm

As part of this model, there have been changes in the approach to reviewing serious incidents with staff involved to encourage active involvement and help reduce feelings of blame which can accompany all staff involved in an incident regardless of their actions. There is emerging evidence the changes are positively received by frontline staff. Please see feedback comments below:

"It was the very first time I had ever witnessed an investigation where the emphasis was on learning and acknowledging the positive aspects of care. I very much appreciated hearing that the patient's family had thought their family member was much improved as a result of our care and I felt valued and appreciated"

"The whole tone of the review was one where kindness and fairness was the overriding feature. I felt supported and although there were some learning points, I was able to think about these and not feel defensive (as has been some staff members past experiences before the new model for learning began to be implemented)"

The attitudes to suicide survey (discussed in 4. 4) is yielding further qualitative feedback on investigations which will be used to inform best practice in supporting staff involved in serious incidents.

Community Care Group Priorities

The initial priority is to complete the actions below following the suicide of a gentleman;

- Training to provide staff with confidence and basic skills in identifying people with depression and possible suicide ideation/intent.
- To increase awareness of how to respond/refer/signpost for help for specific scenarios relating to suicide prevention.
- Helen Boit, Senior Quality and Safety Lead talks in the video about an investigation regarding the death of a gentleman on the caseload of community nurses. This has shaped the above training. In addition the 'story' has been used in several clinical governance groups and the suicide prevention operations group to raise awareness of risk factors for people in other care groups. The gentleman's family have been kept up to date of the investigation and taken comfort for this.

Additional steps are to link this work with other relevant care groups.

Children and Families Care Group Priorities

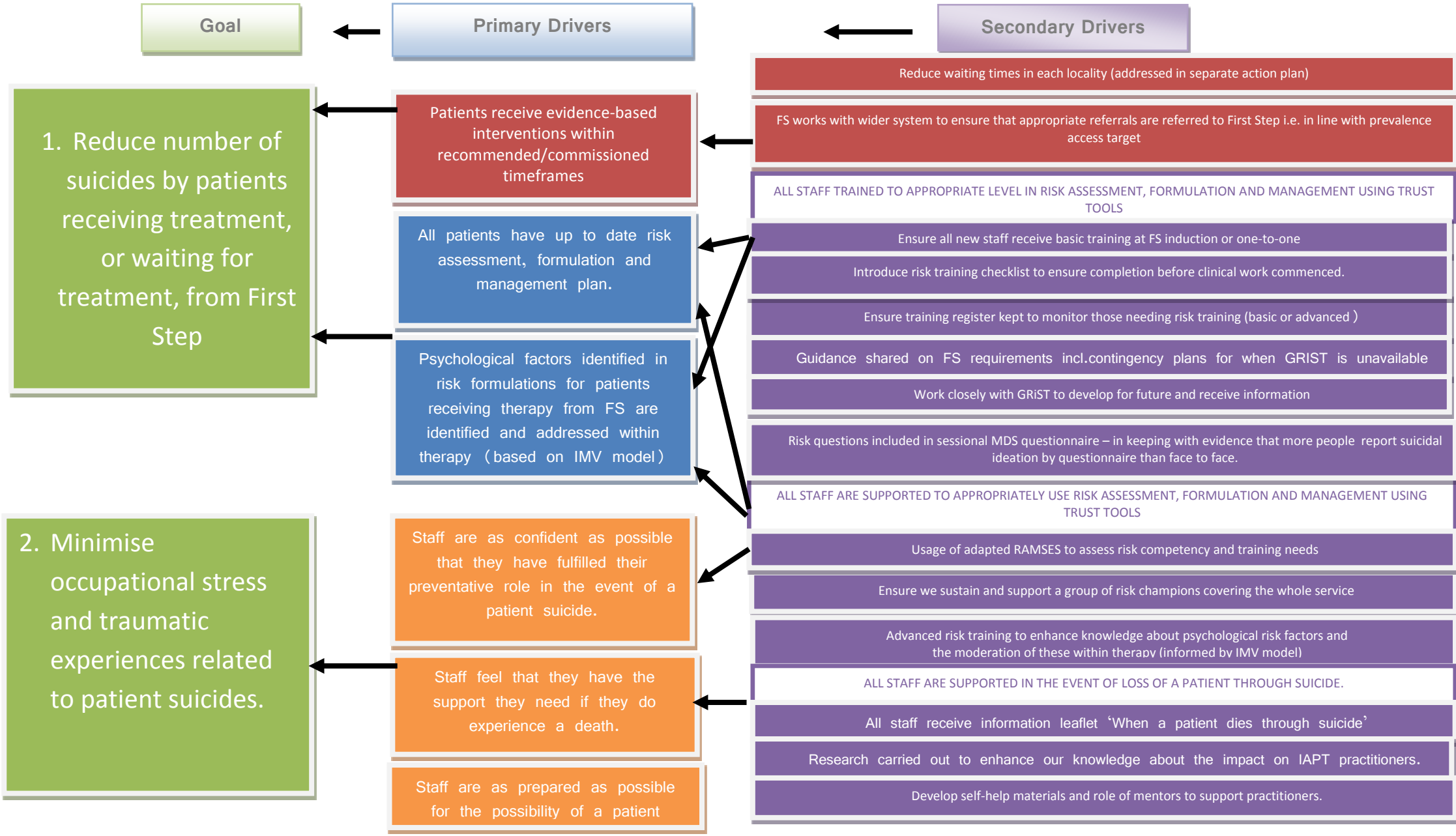
Training on suicide prevention and self-harm has been organised in conjunction with the Cumbria multi agency training sub-group. Consultant Clinical Psychologist, Una Parker has led this for CPFT.
Training programmes are been delivered by Cumbria Mind and Cumbria Self Harm Awareness
Other activities include;

- Embedding learning lessons-thematic review undertaken.
- Improving support for staff involved in serious incidents.
- Disseminating the infographics as posters from the National Confidential Inquiry into Suicide in children and young people (2016).
- Exploring further training for CAMHS staff, particularly around autism.
- Joint learning review with mental health care group.

Specialist Services Care Group Priorities

- Suicide Prevention Project Lead and the Quality and Safety Lead to complete formulation of plan following meetings with all components of the Specialist Care group.
- Agree plan at care group level.
- Basic awareness raising across several networks-to help staff feel more comfortable about talking about suicide with patients.
- To explore learning and training resources for staff supporting people with autism.

Driver Diagram for First Step Suicide Reduction Plan



3.4 Having aligned goals at every level is identified in CPFT's Strategic Plan (2014-19) as the route to working together for patients. There are opportunities now for care groups and networks to work closer together on suicide prevention plans. For example, the Memory and Later Life network in the mental health care group have noted the opportunity to influence the training for community nurses and improve understanding of the different ways suicidality may present in the older population group. Likewise improving understanding of suicidality in people with autism is relevant for all care groups and can feed into several suicide prevention plans.

4. Overarching Suicide Prevention Projects

This next section describes current projects driven centrally in CPFT. Their connectivity with wider systems in Cumbria is outlined.

4.1 Real time alerts

4.1.1 CPFT has been provided from with investment of £25K available on completion of key milestones by the Northeast Academic Health Science Network to developing a real time alerts system and for the Cumbria suicide prevention event discussed in 4.2. There are three core elements to this work;

- Real time alerts to identify individuals and population groups at risk of suicide
- Post suicide intervention
- Earlier information on possible suicides

The long term objectives of this work are that partners coproduce a dynamic information system that supports continuous learning and improvement together resulting in:
- a better experience for those in crisis, their families and carers, the public and staff and that this support community resilience
-integrated working between agencies getting to the right place first time saving lives, time, money, distress and conflict
-rapid shared learning and improvement as the norm where we fall short of these aspirations as a system

4.1.2 The logic diagram on the next page provides an overview of this work;

Inputs → **Outputs**: **Activities**, **Participation** → **Outcome**: **Short**, **Medium**, **Long term**

Situation

There is a need to improve management of crisis in Cumbria by providing an integrated system
There is information held in partner organisations that could support evidence based change
There is a national increase in the proportion of deaths by suicide known to services being in Crisis services

What we invest:-

- Resource?
- Senior leadership time across the system
- Systems relationships and goodwill built within the suicide prevention leadership group
- Time from public health, Police, CPFT, /others for the data set up and testing
- Existing information sharing agreements
- Support from AHSN / AQuA
- Expertise to

What we do

Build a data set over a specific time scale using data available to identify:

- Strategic themes to assist the focus of the service transformation of the Crisis Care Concordat
-
- Potential for operational use of a system day to day to care plan for identified individuals and also to offer all parties feedback as a continuous learning loop
- Early identification of possible suicides in order to better provide support to the bereaved and to practitioners, to identify shared and earlier opportunities for learning and improvement
-

Who we reach

- The Cumbria Suicide Prevention Leadership Group
- Leadership team for the crisis concordat
- Partner organisations at the frontline
- Public, those in crisis and those who care for them by a joined up experience
- All those involved in suicide prevention by a culture shift to early and shared investigation and learning and support of those involved both bereaved and practitioner

Short term Results

A thematic analysis w
be produced to suppo
the Crisis Concordat

There will be active
engagement across th
system in the process
of using evidence in
service design

That we identify
potential suicides earl
through the process t
support shared
investigation, analysis
and learning

That we pilot 'real ti
operational information

Medium term Results

Real time data will b
continuously produced
from police, health an
so social care about
shared handling of cri

There will be the cult
and relationships requ
for shared problem
solving and resolution
individual issues and
continuous learning fo
service improvement

That this impacts
important clinical
outcomes including
experience, morbidity
and mortality

Ultimate impact

Partners coproduce a dynamic information system that supports continuous learning and improvement together resulting in:

-Better experience for those in crisis, their families and carers, the public and staff and that this support community resilience
-Integrated working between agencies getting to the right place first time saving lives, time, money, distress and conflict
-Rapid shared learning and

Assumptions

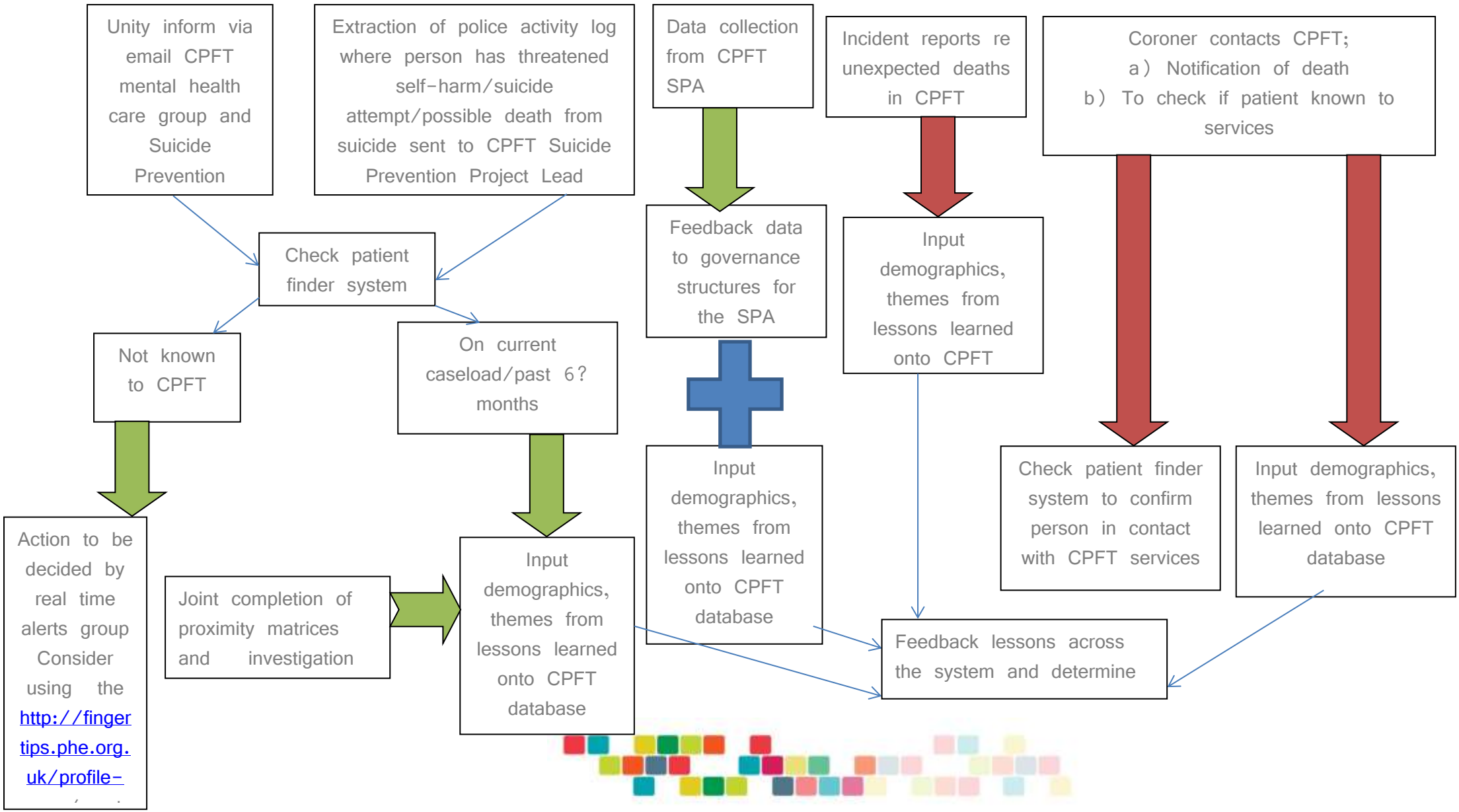
- That the tool is deemed of use to the Crisis Concordat process.
- That the successful bids can be populated with the right staff – skills and numbers.
- That sharing the problem will result in shared problem solving, greater relational coordination and better outcomes for public, patients, staff and organisations shared goals and respectful resolution of difference in the face of limited resource

4.1.3 Work on the real time alerts project is progressing in the following areas;

- Testing and learning from data sharing processes across the system. For example, the in CPFT the IT department is developing a patient finder system which will support central services legal and clinical governance to reduce the time spent searching the various IT systems in CPFT for possible patients. The police have likewise tested their system to understand how relevant information can be extracted from the police activity log
- Information is being shared by Unity and the police with CPFT
- This includes tools from Public Health England (2015) to help prevent contagion of suicide and guide on post suicide interventions
- Post suicide intervention logic diagram has been developed and will be used to start scoping current availability and gaps in this area based on the understanding there is a possible commissioning requirement
- To explore how the dataset of people who require regular intervention from a range of emergency/crisis services can be captured.
- To explore how the fingertip tool can be used to understand the local population
- A draft protocol has been developed by CPFT to identify processes and actions which need to be co-ordinated across the agencies. See diagram 4 on the next page;

4.1.4 The next steps with the real time alerts project is to improve integration between staff working centrally on the real time alerts project, urgent mental health and the police to help drive the project forward at greater pace in addition to developing the infrastructure internally and externally across Cumbria to incorporate other systems where possible. Building relationships across the systems in Cumbria will be important in achieving this. Therefore time and energy will also need to be invested here.

Draft system for processing and sharing learning from real time alerts



4.2 Cumbria suicide prevention events

It is part of the overarching model to use both local and national evidence within frontline services to help build the most effective plans. The two conferences below help provide this knowledge.

4.2.1 CPFT has provided support in terms of speakers and workshops for the last two successive years at the Cumbria Suicide Prevention conference. This conference is coordinated by Cumbria MIND, University of Cumbria and Cumbria Public Health. This conference is attended by a large cohort of student nurses from the University of Cumbria, representatives from statutory and non–statutory services and the public mostly from Cumbria. Last year members of the core group were main speakers and provided an overview of the CPFT 2013 Suicide Prevention Plan. This resulted in feedback which was used to influence the approach of embedding CPFT suicide prevention plan ie. the need to enhance partnership working. The active engagement and support from a member of the public into helping shape the direction of travel via the steering group was also a positive outcome.

CPFT staff have contributed to the annual event by running workshops; 1) the Integrated Motivational-Volitional (IMV) model (referred to in 3.3) to share understanding of the psychology of suicide and supportive interventions and 2) Improving support for staff when a patient dies from suicide.

4.2.2 A further suicide prevention event funded by the AHSN is planned for February 27th, 2017 at Rheged, Penrith. This is a collaborative enterprise between CPFT, the Cumbria/Northeast Academic Health Science Network and CLIC. It aims to bring together professionals and key stakeholders to hear nationally recognised speakers on suicide prevention. For example, key speakers will include leading academics from the Suicidal Behaviour Research Lab based in Glasgow, expert representatives from primary care and children's. It is intended that the conference will raise awareness of the academic findings relating to suicide prevention to inform and enthuse those in attendance and support improved collaborative working across the systems.

4.3 Improving support for staff following a suicide

4.3.1 In CPFT staff in all four care groups have experienced the suicide of a patient. There is an evidence base that shows that most mental health clinicians are likely to experience losing a patient through suicide at some point in their careers (Foley and Kelly, 2007). This impact can be both in the short term and long term. As highlighted in the staff videos the suicide of a patient is an event which has a lasting impact on staff.

4.3.2 It is recognised nationally there has perhaps been a reluctance to discuss the aftermath of a patient suicide, linked to sensitivity towards the practitioners directly involved. Unfortunately this can contribute to practitioners feeling ill prepared in the event of one of their patients taking their own lives.

4.3.3 Where a patient experiences significant harm whilst receiving services from healthcare there is increasing recognition of the significant impact on the practitioner's involved. This is in regard to their wellbeing and how best to engage effectively in learning any lessons from the incident (Dekker, 2014). It is also

important to consider that staff themselves may be at risk of suicide where there has been involvement in a patient safety incident.

4.3.4 It is recognised in CPFT that when a Serious Incident Requiring Investigation (SIRI) occurs extra support for staff is required. This is both from the fact that an enquiry/investigation is needed and also from the nature of the event itself. In addition, the way events are reported in the press and more recently through social media increase the potential for team and individual distress. Senior staff provide additional support at these times regarding facilitating learning from any incident, undertaking or providing guidance on the SIRI and support with any inquest. The Trust values of fairness and kindness are the underpinning principles for this work.

4.3.5 A task and finish group has been set up with currently a small membership of staff from Quality, Safety and Safeguarding, the mental health care group and human resources. This links with CPFT *Improving Staff Health and Wellbeing* priority work and strategy. This strategy has used workshops and meetings with the frontline to gather the perspectives of staff across CPFT on priorities and current and potential support. Improving support for staff involved in a traumatic incident, such as a patient death, was identified as an improvement need in a workshop. The need for improvement in this area is also already evident from the attitudes towards suicide prevention and improving staff support questionnaire. This will be discussed in section 4.4.

4.3.6 Key tasks for the groups are to develop and provide practical information to frontline staff to improve psychological support to staff via leaflets and video, develop and analyse the questionnaire and results from the survey. It is anticipated recommendations from the analysis will include a framework for an improved staff support structure alongside evidence based models. This survey will be discussed in further detail below.

4.4 Survey into staff attitudes towards suicide prevention and staff support following a suicide

4.4.1 It is important to have a good understanding of the attitudes towards suicide prevention and expertise since CPFT delivers such a range of services across the population. A questionnaire was disseminated in September, 2016 to help gain a greater understanding of how suicide prevention and support to staff is perceived. The findings will help prioritise work in the forthcoming year.

The first part of the survey (attitudes towards suicide prevention) was developed by Herron J, Ticehurst H, Appleby L, Perry A, Cordingley L. (2001) and was designed to gather attitudes towards suicide prevention in front-line health staff. The Trust wide Clinical Governance meeting recommended that the survey be disseminated to all staff groups across CPFT, including non-clinical staff. Non-clinical staff also have a key role in suicide prevention, be that estates staff in their anti-ligature work in mental health in-patient wards or IT services who provide the infrastructure to prevent suicides by development and maintenance of IT systems which aid decision-making and record keeping. The survey seeks to help understanding of how all staff perceive, for example, whether suicide is preventable, perceptions about people talking about ending their lives. The survey results will be used to guide future

projects and training. The current response rate is over 600. Last accessed 03/10/16.

4.4.2 The second part of the survey was designed by the task and finish group focussing on improving support for staff following a suicide.
The survey question *"Please provide any additional ideas below on how we could better support staff following a patient suicide or suicide attempt?"* has provided valuable insights and a plethora of suggestions. It could be said that asking the question is an important message to staff in showing we take the issue seriously and care about our staff.
A sample of suggestions for improving the support to staff is in the table below;

Having quick links on the intranet on how to get support and information on the investigation process.
Structured debrief following the incident and the opportunity to feel you can reflect and explore your thoughts and feelings with someone who can help you deal with any personal issues it can bring up, e.g. feelings of failure.
"explain to staff during induction that this is a possibility in their role to experience suicide and explain the procedure and options for support that are available in such an event"
"Thorough review that is not seen as a 'blame game' exercise but seeks to elicit the thoughts and feelings of all affected/involved with the individual. More on the lines of reflective practice that could easily run alongside any statutory investigation that the organisation is obligated to undertake"

4.5 Suicide prevention intranet pages development
4.5.1 A specific project is being undertaken in the Quality, Safety and Safeguarding team to provide clearer, accessible information on key subjects. Suicide prevention will be under the Safety function and it is anticipated this website will be available by the end of October, 2016. From here staff will be able to access quickly key research articles and webpages, lessons learned information, local suicide prevention plans, patient and staff information leaflets relating to suicide prevention and keeping safe. The survey responses from frontline staff will also help influence the quick links to be available.

4.6 Learning from Serious Incidents Requiring Investigations (SIRI)

4.6.1 SIRI reports play a significant role in suicide prevention in terms of how effectively lessons are shared and identified changes to systems and practice are embedded to prevent similar incidents. Several of the action points in the local suicide prevention plans have arisen from experiences of the frontline staff regarding the investigation process itself.

4.6.2 The individual Care Groups and Quality, Safety and Safeguarding Team play a key role in this learning lessons and improvement work from co-ordinating investigation training, supporting care groups with investigations and supporting the development of a governance framework and culture where incidents and investigations are now discussed more openly and evidence of closing the learning loop monitored.

4.6.3 Over the last two years, care groups have developed governance systems to improve sharing and learning from investigations. Identifying learning points and relevant changes is necessary to prevent further harm on the same theme. As mentioned in section 3 several suicide prevention plans include the themes identified in investigations thereby supporting closing the learning loop. Work is ongoing to improve investigations. For example, three further cohorts of staff across care groups completed RCA investigation training provided by an external provider this year. The training supported staff to gain a greater understanding of human factor principles and how to apply in investigations.

4.6.4 The ability of an organisation to learn lessons is aligned with the culture and where investigations continue to be person–focussed rather than considering the wider system influences on the incident, then it is unlikely that underlying themes will be correctly identified and similar incidents prevented. It is anticipated improvements regarding culture and human factors will impact positively on suicide prevention ie. reduced incidents where a specific theme reoccurs.

4.6.5 Embedding human factors principles in SIRI's in CPFT is another area for future development; the Suicide Prevention Project Lead with support from Health Education England based at Aintree Simulation Centre is aiming to develop a tool to guide investigators and reviewers of investigation in ensuring human factors principles are adhered to.

4.6.6 In relation to investigation reports and improving practice it is recognised there is a tendency to use vague terms in describing some learning/change needs. For example, "communication problems" is often used rather than describing the relationship difficulties, behaviours, and/or culture in a team which has contributed to the incident occurring. It is well recognised that team relationship issues, culture and behaviours can play a significant role in the development of patient safety incidents.

4.6.7There is an international evidence base that reports the finding of improved clinically important outcomes where there are good relationships within and between services. There is local evidence both anecdotal and from incidents that indicate that improved relationships between mental health services in Cumbria could be helpful in terms of patient safety, clinical outcomes and experience. A funding grant for £10k has been applied for by CPFT to the AHSN to use a validated measure of perception called *Relational Coordination* which is also correlated to staff experience, resilience and patient and carer satisfaction. The use of the tool will enable raised awareness within the system of the need for mutually respectful and problem solving relationships for better patient and staff outcomes, active measurement and feedback consistent with staff values and Identification of areas of chronic unresolved conflict.

4.7 Training

The 2013 Suicide Prevention Plan stated The Trust will provide/commission a range of training which meets the needs of the different staff groups in the organisation, for example:

- suicide and self-harm awareness training for school nurses
- clinical risk assessment and management for mental health staff
- Skills-based Training on Risk Management (STORM)

This has been achieved. However, there are staff groups who still require bespoke training/educational opportunities. This will be achieved by working with the individual care groups on training needs already identified, such as for those for people with chronic physical health problems, people with autism and those receiving palliative care.

This is in addition to delivering basic awareness around suicide across everyone in CPFT.

Qualitative feedback from the survey has so far indicated that information on suicide is welcomed also by staff not involved in the delivery of direct care in order to help people understand more about suicidality and to be able to respond to people in distress with increased confidence.

The suggestions that suicide prevention should be included in the Trust Induction and Risky Business and the development of online training are next steps along with looking to involve patients and carers as “experts by experience” as appropriate.

5. Conclusion

The 2015/16 suicide prevention report has outlined a model for suicide prevention at the frontline with bespoke suicide prevention plans in services supported by overarching plans where there are commonly held issues.

This year has seen engagement and progress across the trust; the next year will be focussed on making progress against the plans that have been outlined.

Annual Report for CPFT Suicide Prevention Plan
2015 – 2016

Trust Headquarters | Voreda | Portland Place | Penrith | Cumbria | CA11 7QQ
T: 01228 603890 | www.cumbriapartnership.nhs.uk