SUICIDE

NHS

SUPPORT | LEARNING | PREVENTION

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Barnet, Enfield and Haringey
Mental Health NHS Trust

Camden and Islington
NHS Foundation Trust

ABOUT SUICIDE

Our Zero Suicide Ambition: Suicide prevention, learning and support strategy

2021-2026

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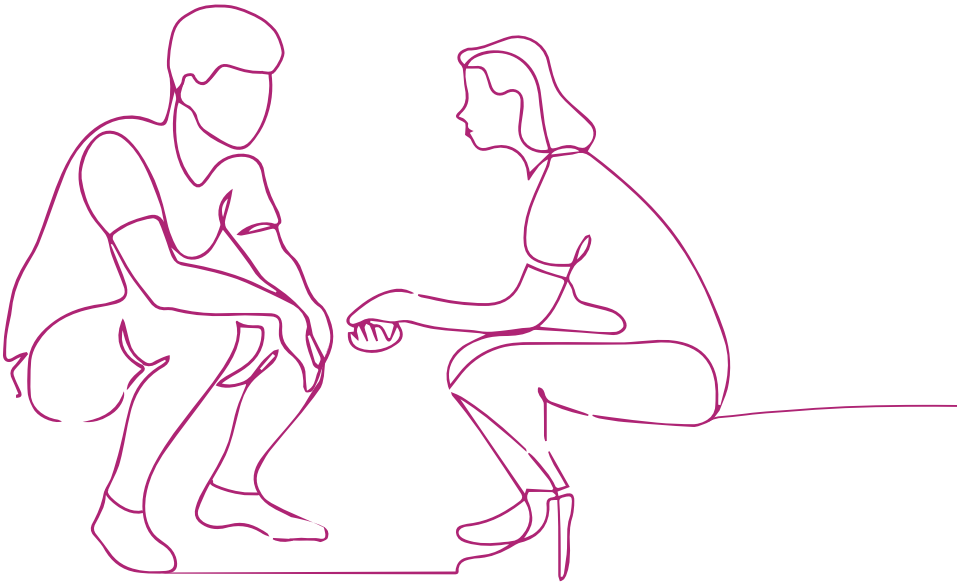
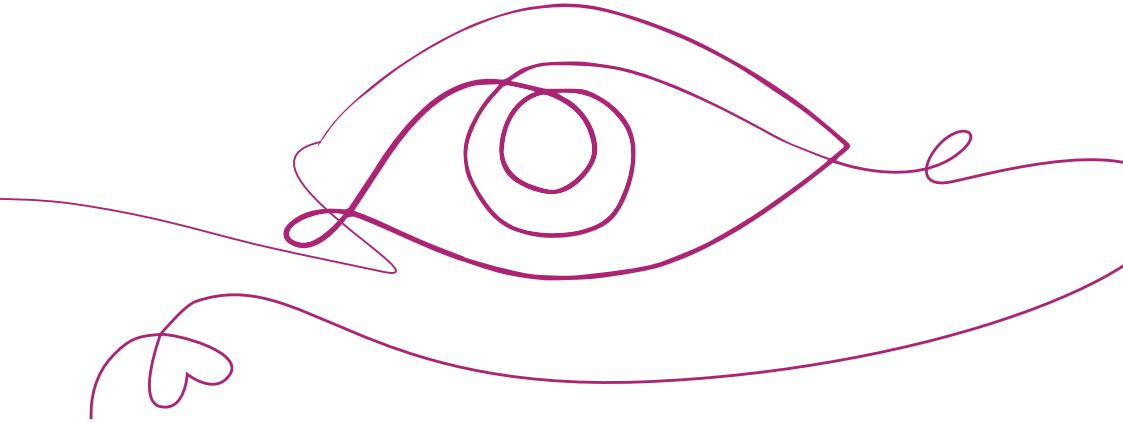


VISION AND OVERARCHING AIM

Our aim is that we will become trauma-informed Trusts with just, fair and inclusive learning cultures, where preventing and learning from suicide is at the heart of our work, and where suicide and suicidal feelings are understood as a human response to distress that deserves attention and a compassionate response.

Our ambition is to reduce deaths by suicide among people under our care to zero, and to significantly reduce suicide in the broader community. We will do this by providing safer services and by working in partnership with our communities to support joint efforts to minimise suicide across each of the boroughs we serve. We also aim to champion and offer timely, compassionate support to those affected by suicide including families, our staff and our communities.



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STRATEGY PRINCIPLES

1. **Everyone in our Trusts has something to contribute to this work – we value the diversity of our shared skills, experience and ideas.**

2. **We respect the unique contribution of the narratives of those lost to suicide and the experience of those affected by suicide and those who live with suicidal thoughts and feelings.**

3. **We recognise that suicide prevention, learning and support are all interconnected, and that we will only achieve better outcomes by focussing on learning from suicide and supporting each other.**

4. **Suicide prevention requires safer care for ALL, irrespective of perceived risk. Strengthening the therapeutic relationship is at the heart of safe care and suicide prevention.**

5. **Suicide relates to many factors, some of which are outside of our control as NHS Trusts. We will work in collaboration with multi-agency partners and communities to make improvements across different systems.**

We will take a collaborative, co-production approach based on Quality Improvement methodology and using data intelligence to test ideas and inform the strategy's ongoing development.

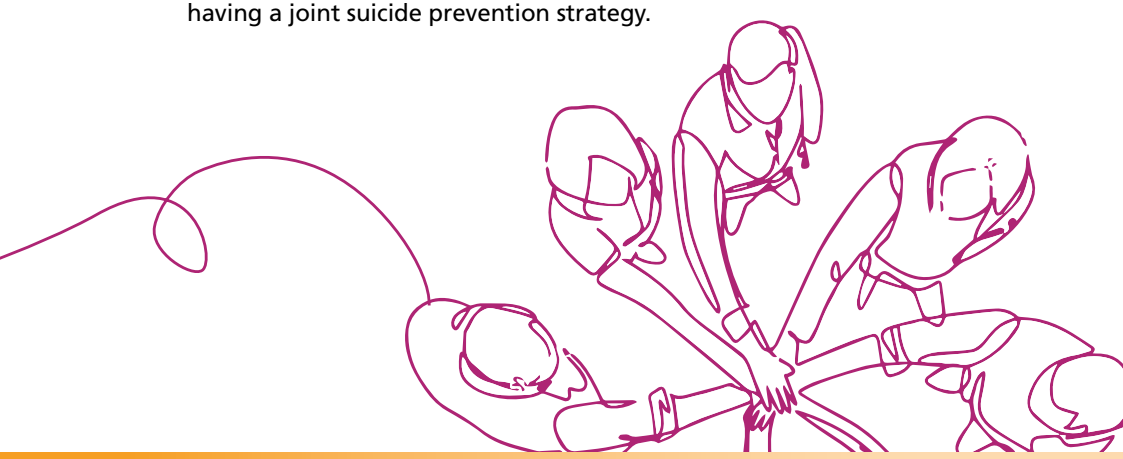
This strategy will contribute to Barnet, Enfield and Haringey Mental Health Trust (BEH)'s strategic aims of:

- Excellence for service users
- Empowerment for staff
- Innovation in services
- Partnerships with others

and Camden and Islington NHS Foundation Trust (C&I)'s strategic focus on:

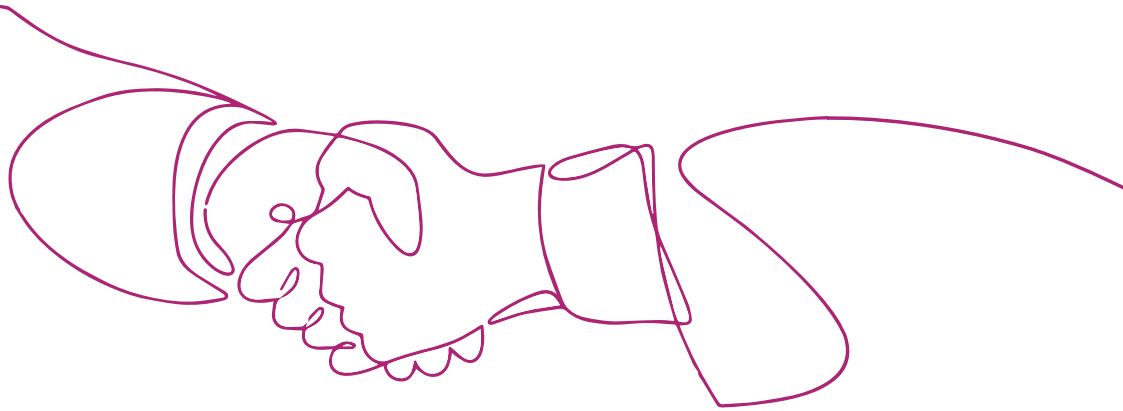
- Early and effective intervention
- Helping people to live well
- Research and innovation
- Keeping our service users, carers and staff safe

For both Trusts, the North Central London (NCL) Community Transformation Programme is well underway, creating an holistic approach to the way we work with GPs, local authorities, voluntary groups and others to improve the mental health and wellbeing of residents across the five boroughs. At the same time, the NCL Integrated Care System is preparing to become a formal statutory body in April 2022. The development of these NCL structures highlights the importance of having a joint suicide prevention strategy.



STRATEGY DEVELOPMENT – BEH

- The strategy was co-produced by the Suicide Strategy Working Group. This group includes representatives from clinical and non-clinical staff from across all divisions, voluntary sector and public health partners, alongside bereaved carers and people with lived (personal) experience of suicidality. We agree that it is vital to create a psychologically safe, transparent culture that supports and respects lived experience, vulnerability and shared thinking.
- The strategy was further developed in consultation with key stakeholders via presentations and workshops. We also cross-referenced our work with national guidance, the National Collaborating Centre for Mental Health Quality Improvement Pilot initiatives in suicide prevention, and evidence-based research.
- To support the successful delivery of the strategy, we carried out a gap analysis of resources, identified process and operational changes needed and created an implementation plan and a training plan.



STRATEGY DEVELOPMENT – C&I

- The C&I Risk Management and Suicide Prevention Task and Finish (T&F) Group was set up in 2018. As with BEH's Strategy Working Group, the T&F Group had representation from clinical and non-clinical staff across all divisions, as well service users, and representatives from our multi-agency partners in public health and the third sector. The Trust has also been working closely with the NCL Suicide Prevention Group, which has multi-agency representation.
- The T&F Group worked to review and develop training, review policy and Electronic Patient Record documentation, as well as enhance communication to the Trust regarding suicide prevention.
- A draft C&I Suicide Prevention Strategy was presented to the Quality and Safety Programme Board in 2021 followed by consultation with service user groups.
- The Suicide Prevention Strategy has been developed with strong alignment to the Trust's formal adoption of the Trauma Informed Approach. This includes revision of clinical risk assessment guidance in the electronic patient record, and the initial development of safety planning aligned to the DIALOG+ care planning tool.

Joint Strategy Development

C&I and BEH are participating in the NCL Mental Health Review, and working more closely together includes taking a joint approach to suicide prevention.

BACKGROUND

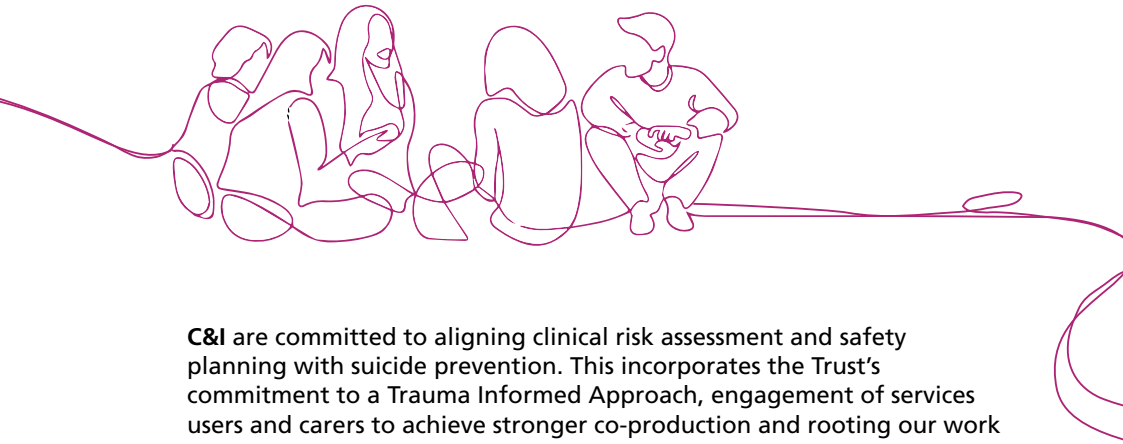
Suicide is a rare and tragic outcome that often leaves a legacy of profound loss for bereaved families and friends, and the emotional impact can also cast a long shadow for professionals across their personal and professional lives. As a complex part of the human condition, no socioeconomic group, culture or demographic is safe from suicidality. We know that it is not only our patients that are affected by suicide, many of our staff will be affected by suicide in their personal lives, and healthcare workers are themselves at risk of experiencing suicidal crises and dying by suicide.

In 2012 the UK launched a National Suicide Prevention Strategy that focussed on support for those bereaved by suicide, risk reduction for high-risk groups, reduction of access to means, and support for research and the media. NHS England took the focus on suicide prevention further in 2016 with the Five Year Forward View, with a commitment to the introduction of multi-agency suicide prevention plans and the aim of reduction in suicide by 10% by 2021.

In 2019 a Zero Suicide Ambition was added for mental health inpatients, requiring all NHS Trusts to put in place plans towards this ambition. The NHS Long Term Plan identifies suicide prevention as a priority for the NHS and pledges to introduce a new Mental Health Safety Improvement Programme with a focus on suicide reduction especially for mental health in-patients, as well as suicide bereavement support services and personalised care to reduce risk in those with mental illness.

As large NHS providers with mental health expertise, BEH and C&I are in a strong position to make a significant contribution to a system-wide approach to suicide prevention across the NCL Integrated Care System.

BEH has had a Suicide Awareness and Prevention Strategy since 2017, based on the 2012 National strategy. Much has been achieved since this time including a large-scale audit of suicide deaths and coroners' reports, suicide prevention training of GPs and members of our Liaison Team, and the establishment of Berwick shared learning events on the topic of Suicide Prevention and also Support After Suicide.



C&I are committed to aligning clinical risk assessment and safety planning with suicide prevention. This incorporates the Trust's commitment to a Trauma Informed Approach, engagement of services users and carers to achieve stronger co-production and rooting our work in strong therapeutic engagement. The Trust has introduced Trauma Informed Approach and Zero Suicide Ambition as initial core training and is committed to the ongoing development of Risk Management and Suicide Prevention training in partnership with BEH.

Partnership work with public health services in all five boroughs, and specialist groups such as the Haringey Suicide Prevention Group, has led to the commissioning and establishment of an NCL-wide Suicide Bereavement Service provided by Rethink. This is available to anyone who lives, works or studies in any of the five boroughs, and no matter how long ago their bereavement.

There is now a recognition that BEH and C&I would benefit from a new joint strategy, incorporating the Zero Suicide Aim for inpatients, but extending the Zero Suicide Ambition to all patients under our care. The strategy aims to reflect the progress made by both Trusts and the national and local desire to be more ambitious in what we can achieve. The joint strategy is an opportunity to:

- Develop and articulate our vision and approach to suicide prevention for all patients under our care, bringing together existing work while identifying gaps and generating new ideas to improve safety within a culture of transparent communication.
- Improve our ability to learn from patients' deaths and from those affected by suicide.
- Support our colleagues and also families affected by suicide.
- Strengthen our partnership working with our community, patients and carers.
- Engage our entire workforce in Quality Improvement work, given the importance of this topic to us all, whether personally or professionally.

NATIONAL PICTURE

The World Health Organization (WHO) estimates that around 700,000 people die each year by suicide, which is 1 in every 100 deaths (WHO, 2019). Every year, more people die as a result of suicide than HIV, malaria, breast cancer, war and homicide. In 2020 there were 5,224 suicides in England and Wales, with the highest rates in middle-aged men aged 45-49 (ONS).

Over a 10-year period to 2018, 27% of those who died by suicide were under the care of mental health services, and these represent an opportunity for prevention (National Confidential Inquiry into Suicides and Safety in Mental Health - NCISH, 2021). Suicides by those who are seriously ill and are being looked after as inpatients are low and falling. In 2018, there were 74 inpatient deaths by suicide in the UK (excluding Northern Ireland), around 4% of all patient suicides (NCISH, 2021). This is a continuation of a downward trend since 2011.

Groups of concern highlighted by the most recent NCISH report (2021) included:

- People who live alone – nearly half (48%) of all suicides from 2008-2018. Compared to those who did not live alone, they were more likely to be over 45, unemployed, on long-term sick leave, and single or widowed. They also had more conventional risk factors for suicide including previous self-harm, and alcohol and drug misuse.

- Suicide by people of different minority ethnicities (7% of total) were heterogenous, indicating that different factors apply for different groups.

The National Confidential Inquiry into Suicides and Safety in Mental Health (NCISH) has analysed suicide data for mental health patients over the last 20 years. Based on this data, they have devised recommendations for 10 main ways mental health organisations can improve safety as pictured below.

Diagram reproduced from the NCISH publication 'Safer Services: A toolkit for specialist mental health services and primary care'

LOCAL PICTURE

Rolling three-year average figures are an appropriate benchmark to use when looking at suicide rates, as the absolute numbers involved per head of population are thankfully very small. The table below shows the data from the last five years as rolling three-year averages (Office for National Statistics). These show that London generally has a lower suicide rate that the rest of England, although inner London rates are slightly higher.

Rolling three-year average per 100,000 population

Area	2018-2020	2017-2019	2016-2018
England	10.4	10.1	9.6
London	8.0	8.2	8.1
Outer London	7.4	7.5	7.5
Inner London	8.4	8.8	8.5
Camden	12.7	11.3	10.4
Islington	8.3	10.4	10.1
Haringey	8.0	9.6	8.0
Barnet	5.8	6.7	6.9
Enfield	5.8	5.9	6.2

The five boroughs have different profiles, with Barnet and Enfield located in outer London and having, on average, older and more stable populations. Haringey, Camden and Islington are all located in inner London, where populations tend to be younger and experience more flux – especially so for Camden, which may contribute to it now having the highest suicide rate of all 32 London boroughs. Islington and Haringey have suicide rates below the inner London average. The ONS has identified a background trend of increasing suicide rates in the South East, especially among men.

WHAT OUR DATA IS TELLING US

At BEH, we track rates of suspected suicides measuring 'days between suicides', in order to most helpfully capture patterns in the context of relatively rare events. At C&I, we monitor 'days between deaths from self-harm', which is effectively the same metric.

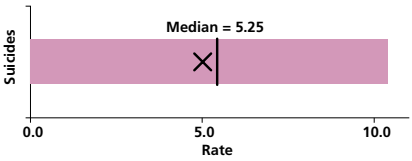
It is worth noting that due to COVID-19 we are not in a steady-state situation, and so this data will need to be interpreted with caution, and in combination with more qualitative narrative data capture to obtain a more rounded picture of patterns of suicide over time.

NCISH Benchmarking Data

The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) provide an annual benchmarking service to Trusts.

BEH benchmark

The latest benchmarking data from the NCISH shows that the suicide rate for BEH patients is below the median for mental health providers across, at a rate of 4.79 per 10,000 people under mental health care. This is despite having a higher percentage of patients on the Care Programme Approach (a package of care for people with mental health illnesses) than average for the country (13% compared to national rate of 10%).

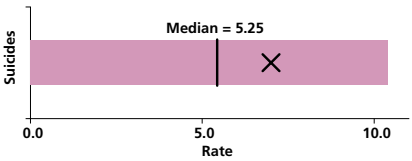


Suicide rate

The suicide rate in your Trust was 4.79 (per 10,000 people under mental health care) from 2016-2018.

C&I benchmark

The latest NCISH data for C&I shows it is above the median rate at 6.75 per 10,000 people under mental health care.



Suicide rate

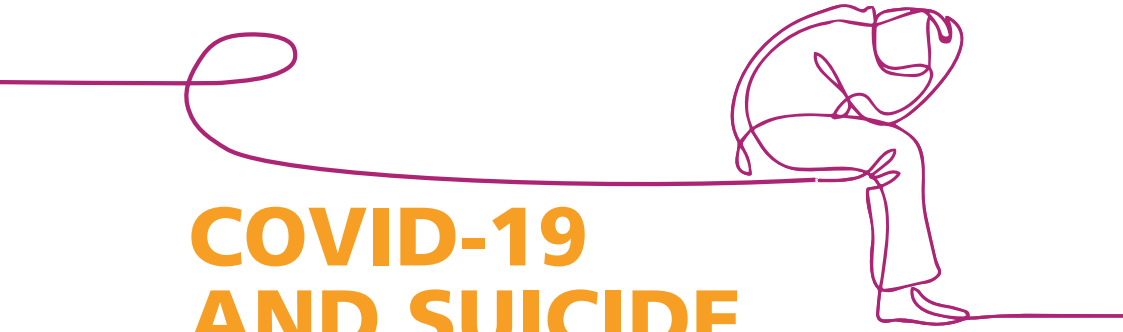
The suicide rate in your Trust was 6.75 (per 10,000 people under mental health care) from 2016-2018.

WHAT OUR LIVED EXPERIENCE IS TELLING US

We know that patients with suicidality do not always have positive experiences of our services, and that there is much more we can do to provide continuity and accessible care for those in the midst of a suicidal crisis. Carers tell us they can feel left out of their loved ones' care, and uninformed when a crisis arises. Similarly, bereaved carers tell us that the support offered after a suicide is at best variable, and often very scarce.

One family member told us that after his wallet was stolen the police immediately offered counselling via Victim Support, but in contrast, following the death of his son by suicide, he was given no signposting or any support at all. Families often would like to be more involved in the serious incident investigation and work done to improve care after a death. Those bereaved by suicide (both families and professionals) must endure the coroners court, and often report this as a very uncertain and highly stressful time where more practical and emotional support is needed.

From workshops conducted with staff and from work done nationally, we know that suicide has a profound effect on professionals involved in the person's care. Therapists can be left with significant trauma symptoms of guilt, anxiety, shame and grief reactions, often with long-lasting impact on their confidence and relationships with colleagues and patients.



COVID-19 AND SUICIDE PREVENTION

Although we hope that the strategy will outlive the COVID-19 pandemic, given the profound impact on people's lives and the changes we have needed to make the way we work as mental health trusts, we see it as essential that the strategy aims and approach align with the evidence base around suicide prevention in this context.

We know that the pandemic has caused an increase in stressors such as social isolation, loneliness, entrapment, and anxieties about education or employment which may be associated with an increase in suicide risk. There has also been an increase in previously established risk factors for suicide such as financial stress, loss of employment, domestic violence and alcohol consumption.

Over the course of the pandemic, access to NHS services and service configuration changed, leading more people to turn to voluntary services and there was a reduction in the availability of face-to-face support.

Proactive approaches to suicide prevention during the pandemic were important in mitigating the increased risk factors. At C&I, the Mental Health Crisis Assessment Service (MHCAS) was launched at the start of the first lockdown in 2020, to provide a centralised and accessible service where service users could be safely assessed while A&E services were limited. The success of this service means that the MHCAS will be retained as we move out of the pandemic.

The long-term mental health effects of the pandemic may be profound. In the short term, the ONS reported that there was not an increase in suicide rates during the initial stages of the pandemic, as had been predicted. In fact, rates fell in April to July 2020 (ONS, September 2021). The NCISH also reported that early data from real time surveillance systems up to October 2020 did not show increases in suicide rates. However the long-term impact of the pandemic remains uncertain, especially in the face of economic uncertainty.

COVID-19 AND SUICIDE PREVENTION

In this strategy we have sought to apply existing knowledge on suicide prevention to the pandemic context, and we have also incorporated specific nationally recommended interventions in relation to suicide prevention in the pandemic context and also recent COVID-specific guidance from NHS England/Improvement. These include:

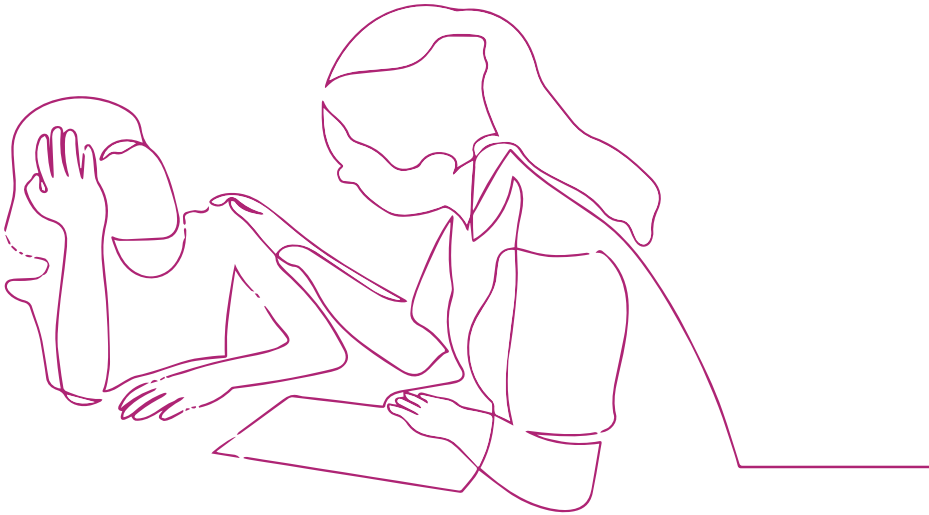
- delivering care in different ways, such as digitally, to reach high risk populations
- developing support for health care staff affected by adverse exposures
- ensuring frontline staff are adequately supported, given breaks and Personal Protective Equipment, and can access additional support
- developing clear pathways for those experiencing suicidal crisis, including access to remote consultation
- developing of our 24/7 single point of access/crisis helplines with digital resources to train our workforce
- continuing to provide talking therapies (known as Improving Access to Psychological Therapies or IAPT) using digital delivery of evidence-based online interventions and applications
- ensuring accessible help is available for bereaved individuals
- ongoing development of suicide postvention services
- signposting to support for domestic violence and alcohol misuse
- championing safety nets for those in financial difficulties and regular check-ins for colleagues, family and friends, and sensitive media reporting in line with existing guidelines.

As a dynamic situation, our strategic recommendations will be updated according to further changes in local and national intelligence in this area.

BENEFITS AND IMPACT

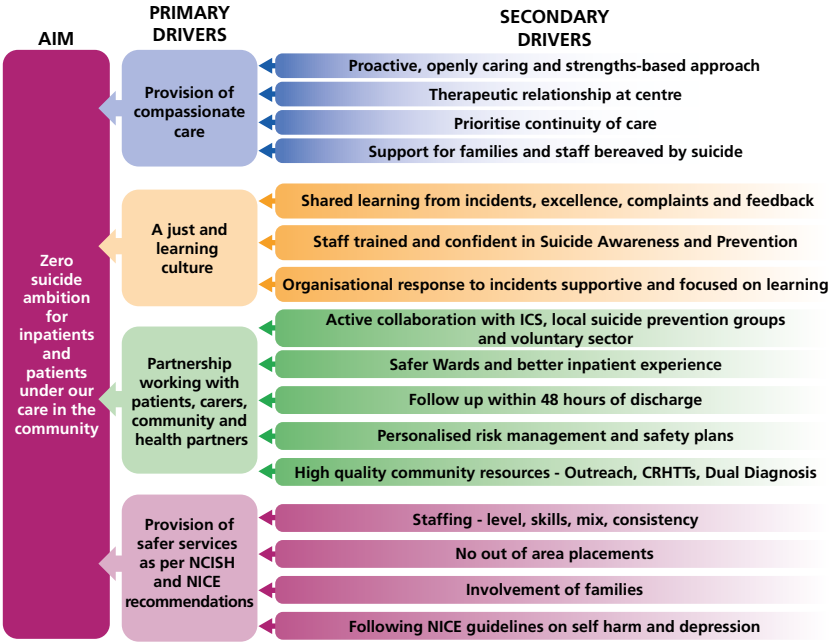
There are benefits to focussing on suicide prevention, both in terms of the individual person and also on those potentially impacted by the death. We know that suicide is not an inevitable outcome, with evidence that many survivors of interrupted suicide attempts feeling relief at being saved and going on to lead long and fruitful lives. There is an opportunity, through focus on prevention to celebrate the years gained, and to also prevent the significant impact on others that any individual suicide causes.

Each suicide is thought to impact on as many as 135 individuals with some less affected, many bereaved and a core of individuals who are permanently changed by their loss. The grief cause by suicide is often complex, and bereaved relatives and staff involved may also experience significant secondary trauma symptoms and a much higher risk of suicide themselves. The estimated cost of each suicide is in the region of £1.7m (London School of Economics).



JOINT STRATEGY FRAMEWORK

We have identified four primary drivers as most likely to lead to success in achieving our aim to maintain zero suicides within inpatient settings and achieve an ongoing reduction in suspected suicides by people living in the community under our care.



Key

CRHTT	Crisis Resolution and Home Treatment Team
ICS	Integrated care system
NCISH	National Confidential Inquiry into Suicides and Safety in Mental Health
NICE	National Institute for Health and Care Excellence

The primary drivers are:

1. Compassionate care
2. A just and learning culture
3. Partnership working with patients and carers and community and health organisations
4. Safer services

1

Compassionate care

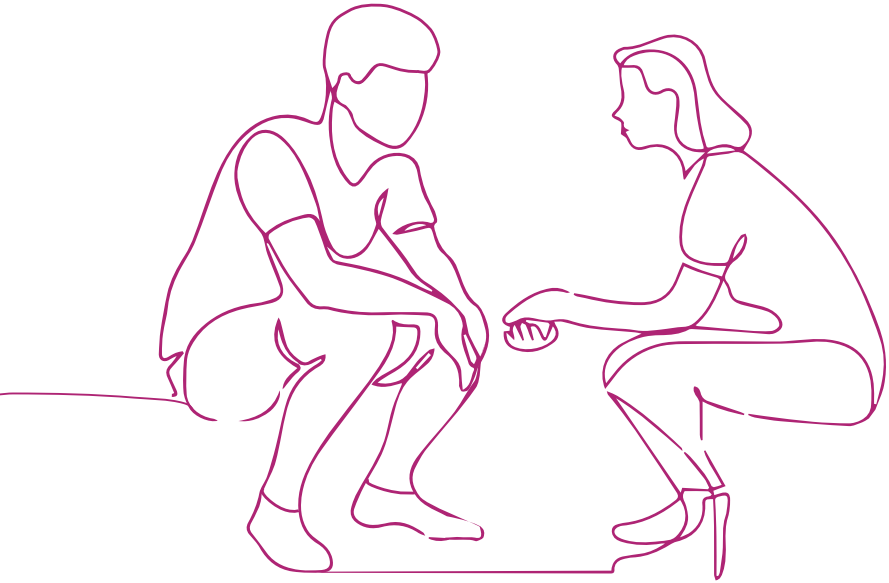
Evidence shows that approaches that place the therapeutic relationship at the centre of an intervention and combine a non-judgemental approach, warmth, genuineness and empathy and promote "connectedness" are important in reducing deaths by suicide. Models using an openly caring approach with strong continuity of care and listening approaches have been effective at reducing deaths elsewhere in the UK. The centrality of the therapeutic relationship is also essential to the trauma informed approach, which we are taking across all our services.

We know that at both Trusts, high caseloads, a focus on risk-management and the impact of emotionally challenging work can all impact on clinicians being able to provide the continuity of care and compassion that we know is protective. This can be especially true in our crisis team settings where staff are under significant pressure, working with very unwell people, and exposed to the impact of suicide in their patients.

We will identify areas for improvement in compassionate care, learn from other Trusts and embed this learning into Trust-wide approach to clinical care. Both Trusts have been taking part in a national trial of the Open Dialogue approach, which is founded on principles of continuity of care and compassionate listening. At C&I, we are working towards becoming a trauma-informed organisation. A Trauma Informed Approach (TIA) e-learning module has already been rolled out to all clinical staff, and regular Trauma Informed Collaboratives are held where staff can share good practise. The TIA enables staff to strengthen their therapeutic engagement with service users, which is an essential protective factor in preventing suicide.

1

Compassionate care also involves including supporting those bereaved by suicide, including families and staff members. BEH has established the 'Here for you' critical incident support framework for staff, and plan to create a new system via the incident reporting system, that ensures all families are promptly contacted, supported and signposted to further support following a death of a patient. C&I frameworks and systems will be reviewed and formalised to provide similar responses. Since late 2021, C&I and BEH have been working with the NCL Support After Suicide bereavement service providing by Rethink.



2

A just and learning culture

A just culture maintains that while individuals remain accountable for following protocols and polices and for their individual practice, there is an organisation-wide emphasis on safety that focuses on system issues that contribute to errors and harm. This culture empowers staff to feel confident to voice concerns about safety and patient care and to actively engage in work towards improvements.

We know that anecdotally, staff often feel a complex mix of feelings in relation to serious incidents and suicides, including guilt, self-blame, isolation, anxiety and hurt. So it is important that support for staff is integral to any approach that is aiming to learn from experience and reduce deaths. A quality improvement approach, with the concept of psychological safety as a central feature, lends itself well to this approach and fits well with a whole-Trust culture of quality improvement.

We plan to embed shared learning opportunities both across each Trust and in partnership with the wider community. We have also identified the need to enhance our processes of learning from suicide deaths, by routinely including bereaved carers in our Serious Incident Investigation process and by learning from families' narratives more broadly. We will also work to ensure all staff, and multi-agency partners, can access this learning.

Both BEH and C&I have signed up to the Zero Suicide Alliance (ZSA) which is a collaboration of National Health Service trusts, charities, businesses and individuals who are all committed to suicide prevention in the UK and beyond. ZSA have a suite of e-learning tools to support raising awareness and skills training for people supporting those who may be in a suicidal crisis.

Using the Zero Suicide Alliance e-learning, BEH has included suicide prevention as part of mandatory training for all staff. C&I has included it as mandatory for clinical staff and plan to extend this to all staff. Both trusts aim to supplement this training with a more in-depth bespoke suicide prevention training offer led by clinicians alongside those with lived experience, for those in frontline roles and those with a special interest in this topic. We also plan to introduce local suicide prevention champions in all divisions to share key messages and learning further across the organisation.

3

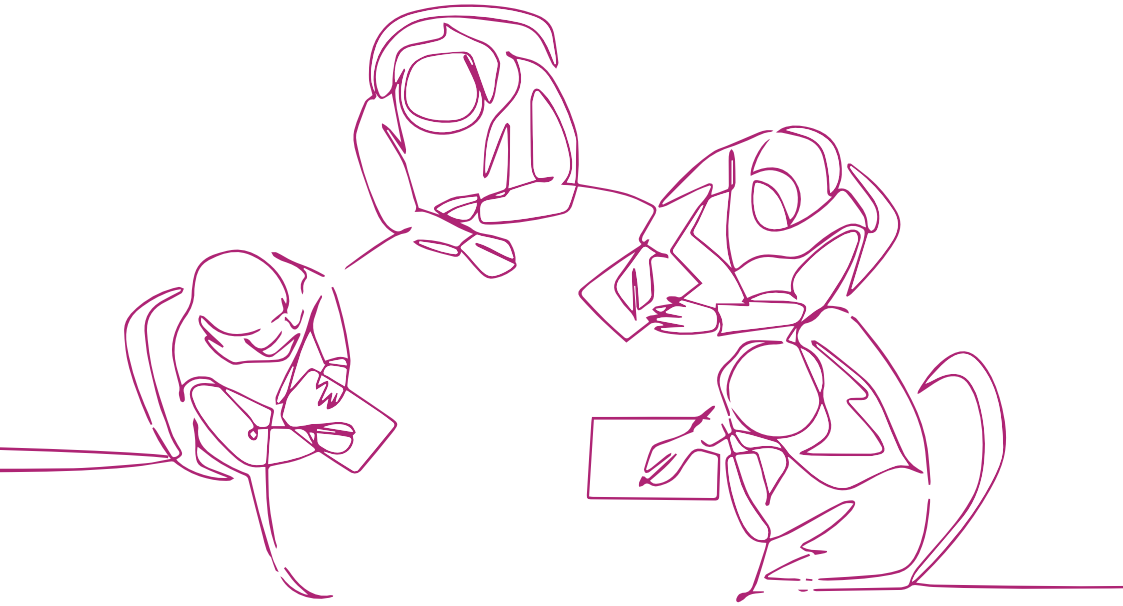
Partnership working with patients and carers and community and health organisations

It is important that our work is part of a broader approach to suicide prevention based on the Cross Governmental Suicide Prevention Work plan (2019) via Local Suicide Prevention Groups and Planning. We will champion a collaborative process of learning and sharing expertise with other trusts and organisations. We will also continue to champion the NCL-wide Suicide Prevention Steering Group to oversee work across the sector and ensure that suicide prevention is coordinated and prioritised across the sector.

4

Safer services

As it is impossible to predict which of the individuals under our care will die by suicide over the long term, we aim to provide safer care for all, with a particular focus on areas of care which are known to be important in reducing deaths from suicide. This is in line with the NCISH guidance in this area. We intend to audit all our services using the NCISH Toolkit for Safer Services to identify gaps and then work collaboratively to support improvements in care in these areas. We will also champion the mitigation of risk factors by ensuring that co-produced personalised safety planning is used throughout each Trust.



Leadership and governance of this strategy

Delivery of this strategy at BEH will be overseen by the Deputy Medical Director reporting to the Safety, Effectiveness and Experience Group.

Delivery of the strategy at C&I will be overseen by the Deputy Director of Nursing and Director of Psychological Therapies, reporting to the Quality and Safety Programme Board. Clinical leadership of the strategy will be provided by the Head of Psychology for the Hospital Division.

A joint reference group will be established and will include experts by experience, stakeholder partners, and clinicians from both Trusts. The reference group will oversee the safe and compassionate review of serious incidents involving a death by suicide or attempted death by suicide, to ensure service users, carers and staff are supported. Wider governance will include the identification of lessons learnt, and their sensitive and effective communication and governance. Data management and use will be strengthened.

get in touch

We are aware that this topic is a difficult one and can trigger distress. If you or someone close to you needs to talk about suicidality, any time of the day or night, you can:

- call the Samaritans free on **116 123**
- text "SHOUT" to **85258** to contact the Shout Crisis Text Line, or text "YM" if you're under 19
- if you're under 19, you can also call **0800 1111** to talk to Childline. The number will not appear on your phone bill.

If you are experiencing a mental health crisis, you can call one of our Freephone 24-hour Crisis Helplines:

- If you live in Barnet, Enfield or Haringey, call **0800 151 0023**
- If you live in Camden or Islington, call **0800 917 3333**

For staff

If you are interested in learning more about our work on this agenda, please visit your Trust's intranet page:

- **For BEH:** Working for the Trust > Suicide Awareness, Prevention and Support **http://staff.beh-mht.nhs.uk/working-for-the-trust/suicide-awareness-and-prevention.htm**
- **For C&I:** Safe care > Suicide Prevention and Support After Suicide **https://intranet.candi.nhs.uk/safe-care/suicide-prevention-and-support-after-suicide**

Produced by the Communications Department at Barnet,
Enfield and Haringey Mental Health NHS Trust

Barnet, Enfield and Haringey
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