Mersey Care NHS
NHS Foundation Trust

TRUST-WIDE CLINICAL POLICY DOCUMENT

ZERO SUICIDE POLICY

Policy Number:	**SD38**
Scope of this Document:	**All Staff**
Recommending Committee:	**Zero Suicide Programme Board**
Approving Committee:	**Executive Committee**
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Lead Executive Director:	**Medical Director**
Lead Author(s):	**Associate Medical Director Zero Suicide Programme Board**

2016 – Version 2

Quality, recovery and wellbeing at the heart of everything we do

Mersey Care NHS
NHS Foundation Trust

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ZERO SUICIDE POLICY

Further information about this document:

Document name	**SD38 Zero Suicide Policy**
Document summary	**Mersey Care takes the view that suicide should be regarded as an avoidable death, which is both preventable and amenable to care. This policy sets out the standards of care that will be offered to all service users who express suicidal ideas to ensure they have the highest quality assessment, support and treatment until they have recovered and are safe.**
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Published by Copies of this document are available from the Author(s) and via the trust's website	**Mersey Care NHS Foundation Trust** **V7 Building** **Kings Business Park** **PrescotLiverpool, L34 1PJ** **Your Space Extranet: http://nww.portal.merseycare.nhs.uk** **Trust's Website www.merseycare.nhs.uk**
To be read in conjunction with	**SA2: Effective Management of Risk** **SA3: Reporting, management and review of adverse incidents** **SA10: Use of clinical risk assessment tools** **SD01: Leave for an informal inpatient** **SD04: Management of clinical risk through supportive observation** **SD19: Advance statements** **SD21: Care Programme Approach** **MC02: Assessment of Capacity**
This document can be made available in a range of alternative formats including various languages, large print and braille etc	

Version Control:

		Version History:
V2	First policy update, since Zero Suicide Policy launch in September 2015	September 2016

SUPPORTING STATEMENTS

this document should be read in conjunction with the following statements:

SAFEGUARDING IS EVERYBODY'S BUSINESS

All Mersey Care NHS Foundation Trust employees have a statutory duty to safeguard and promote the welfare of children and vulnerable adults, including:

- being alert to the possibility of child/vulnerable adult abuse and neglect through their observation of abuse, or by professional judgement made as a result of information gathered about the child/vulnerable adult;
- knowing how to deal with a disclosure or allegation of child/adult abuse;
- undertaking training as appropriate for their role and keeping themselves updated;
- being aware of and following the local policies and procedures they need to follow if they have a child/vulnerable adult concern;
- ensuring appropriate advice and support is accessed either from managers, *Safeguarding Ambassadors* or the trust's safeguarding team;
- participating in multi-agency working to safeguard the child or vulnerable adult (if appropriate to your role);
- ensuring contemporaneous records are kept at all times and record keeping is in strict adherence to Mersey Care NHS Foundation Trust policy and procedures and professional guidelines. Roles, responsibilities and accountabilities, will differ depending on the post you hold within the organisation;
- ensuring that all staff and their managers discuss and record any safeguarding issues that arise at each supervision session

EQUALITY AND HUMAN RIGHTS

Mersey Care NHS Foundation Trust recognises that some sections of society experience prejudice and discrimination. The Equality Act 2010 specifically recognises the *protected characteristics* of age, disability, gender, race, religion or belief, sexual orientation and transgender. The Equality Act also requires regard to socio-economic factors including pregnancy /maternity and marriage/civil partnership.

The trust is committed to equality of opportunity and anti-discriminatory practice both in the provision of services and in our role as a major employer. The trust believes that all people have the right to be treated with dignity and respect and is committed to the elimination of unfair and unlawful discriminatory practices.

Mersey Care NHS Foundation Trust also is aware of its legal duties under the Human Rights Act 1998. Section 6 of the Human Rights Act requires all public authorities to uphold and promote Human Rights in everything they do. It is unlawful for a public authority to perform any act which contravenes the Human Rights Act.

Mersey Care NHS Foundation Trust is committed to carrying out its functions and service delivery in line the with a Human Rights based approach and the FREDA principles of **F**airness, **R**espect, **E**quality **D**ignity, and **A**utonomy

CONTENTS

APPENDICES

1 PURPOSE AND RATIONALE

1.1 Purpose

1.1.1 Suicide is an avoidable death. It is both preventable by wider public health interventions, but also amenable to high quality evidence based care.

1.1.2 About 27% of people who die by suicide are under the care of a specialist mental health team. These people are the primary focus for the trust as they are the highest risk and amendable to our care.

1.1.3 The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCI) checklist 'Twelve Points to a Safer Service' is based on recommendations from a national study of patient suicides and provides key guidance for mental health services (Appleby 2012).

1.1.4 This policy sets out the standards of care that will be offered to all service users who express suicidal ideas to ensure they have the highest quality assessment, support and treatment until they have recovered and are safe.

1.2 Rationale

1.2.1 Approximately 1 million people die by suicide each year across the world, and approximately 6,000 in the UK. Most are men (75%) and it is estimated to be the leading cause of death in men under the age of 50, and one of the leading causes of premature death. Suicide rates in the UK hit an all time low in 2007, but are currently increasing. Many approaches have been tried including a national suicide prevention strategy.

1.2.2 Mersey Care, along with colleagues in South West and East of England, have been inspired by the pioneering approach within the Henry Ford Hospital System, Detroit, Michigan (USA). The Henry Ford Hospital System managed to implement a philosophy and practice of 'perfect depression care' which led within four years to a 75% drop in suicides, and eventually to years without a single suicide (Hampton, T. (2010). Depression care effort brings dramatic drop in large HMO population's suicide rate. JAMA, 303, 1903-195).

1.2.3 Mersey Care NHS Trust believes that a similar approach can be implemented in the UK, and are the first mental health trust to publically commit to the ambitious aspiration to eliminate suicide from within its care over the next five years.

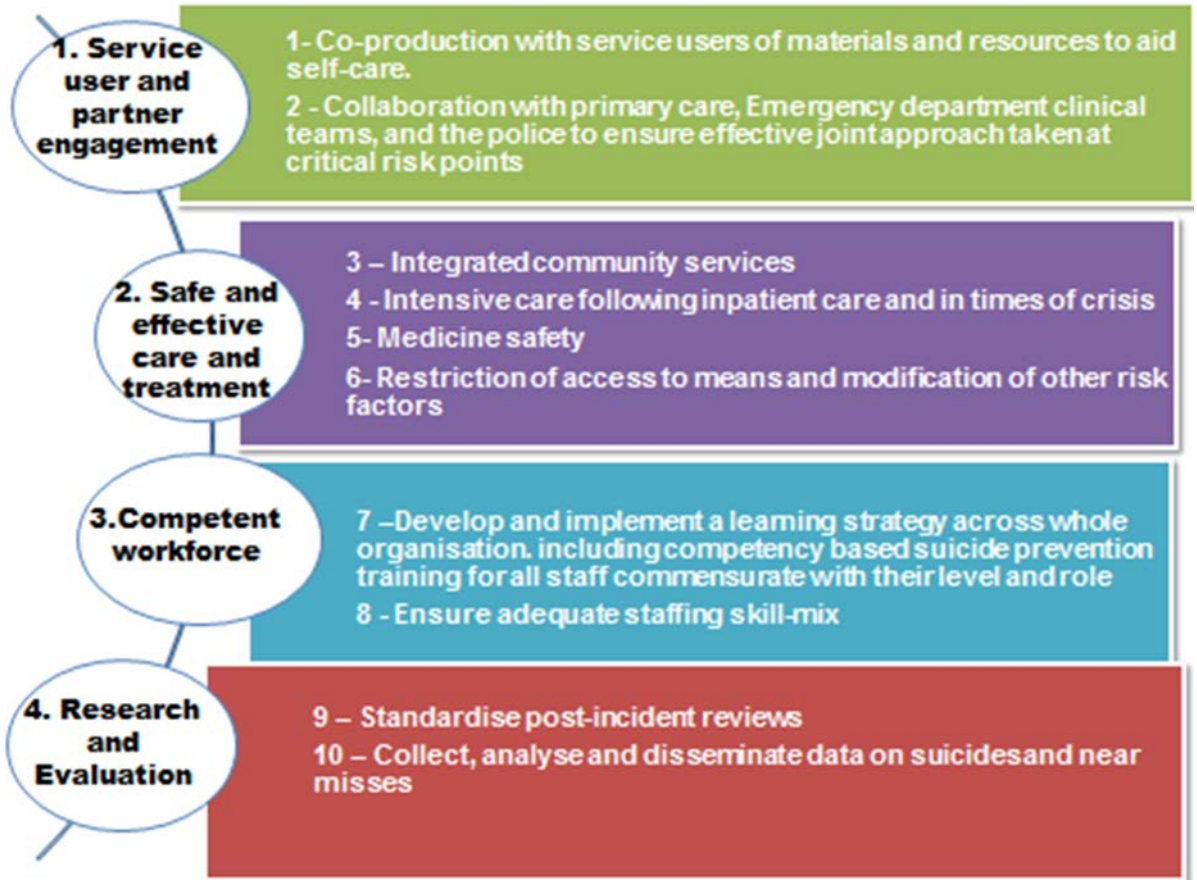
1.2.4 The Zero Suicide approach aims to improve the care provided and outcomes for people at risk of suicide under the care of Mersey Care NHS Trust.

2 OUTCOME FOCUSED AIMS AND OBJECTIVES

2.1 Our Approach

2.1.1 Based on the evidence base and our analysis of the data showing key patterns, causes and risk points for suicide, the Mersey Care NHS Trust Zero Suicide

approach, will focus on 4 priority areas, and 10 key actions set out in the diagram below.



2.2 Our approach in detail

Priority area 1: Service user and partner engagement

Action 1 - Co-production of materials and information with service users, carers and family members to support self-care, and following the principles of the Triangle of Care. A variety of formats appropriate to the person are available.

Action 2 - Collaboration with primary care, Accident and Emergency clinical teams, and the police to ensure that effective joint approaches are taken at critical risk points

Priority area 2: Safe and Effective Care and Treatment:

Action 3 - Integrated community services are shown in national evidence to be effective in preventing suicide. For Mersey Care, integrated community services are characterised by:

a. A single point of access for all service users in crisis, 24 hours a day, as part of the assessment and immediate care service. This will ensure rapid response to a crisis, short term input e.g. A&E liaison, and whenever possible, appropriate alternatives to admission.

b. Rapid access to assessment and treatment, following evidence based treatment pathways and protocols

c. Integration of assertive outreach, addiction and criminal justice liaison services.

Action 4 - Intensive care especially follow-up after inpatient and in times of crisis means that:

a. All service users will have follow up from inpatient discharge for at least 7 days as a minimum, and only be discharged when the safety plan has been explicitly acknowledged and agreed by the new care agency e.g. GP, CMHT.

b. Individuals in crisis will be engaged proactively in interventions to help to lower their risk profile.

Action 5 - Medicine safety

a. The Medicines Policy will set out best practice for improving adherence with medication and the health record will prompt regular checks of adherence.

b. Use of atypical antipsychotic medication where appropriate encouraged and clozapine use to be benchmarked to minimise duration of untreated psychosis and undertreated psychosis.

Action 6.1 - Restriction of access to means of suicide, means that:

a. Potential ligature points will be removed from in patient wards based on environmental risk assessments, supported by monthly reviews. Where it is not possible to remove these, staff will be aware of where they are and appropriate risk assessment and mitigation plans will be in place for those which cannot be removed.

b. Any service user with a history of self-harm within past three months to receive no more than two weeks supply of medication.

Action 6.2 - Modification of risk factors means that:

a. Psychologically- informed risk formulations and safety plans will be implemented as a therapeutic intervention to help identify risk and protective factors, within a culturally competent framework. Collaborative work with the patient to promote recovery work and future self-management strategy.

b. Targeted specific interventions to increase protective factors including social inclusion through our Recovery College, psychosocial interventions, and if alcohol is identified as a risk factor appropriate specific actions will be taken to reduce this risk.

Priority Area 3: Competent Workforce

For Mersey Care, developing a competent workforce to prevent suicide means:

Action 7.1 - Development of an organisation wide learning strategy to implement a program of training with defined measurable outcomes.

Action 7.2 - Competency based suicide prevention training for all staff appropriate for their level and role. All Staff will receive training to ensure they are confident and competent when assessing suicide risk, within a culturally competent framework

Action 8 - Ensure there is an adequate staffing skill-mix to deliver appropriate evidence based interventions

Priority Area 4: Research and Evaluation

We will develop an evidence base around suicide prevention in mental health services, by focusing on:

Action 9 - Post incident reviews will be standardised to favour learning and collection of relevant data.

Action 10.1 - Data will be collected, analysed and disseminated on suicides and near misses to understand the epidemiology of suicide within our service

Action 10.2 - We will develop a research strategy in conjuction with academic partners to build up a framework to analyse and evaluate outcomes of implemented interventions.

3 SCOPE

3.1 Mersey Care NHS Trust staff have a responsibility to deliver the standards and targets as outlined by national strategies. The focus of the Trust is the reduction in suicide amongst health and social care services users. This document focuses on strategies to achieve this goal.

3.2 This policy will be relevant to anyone directly involved in assessment and management of the suicidal person, and in wider ranging roles such as policy makers and managers.

4 DUTIES

4.1 **Board of Directors** - The Board will be responsible for overseeing the Trust's Zero Suicide Strategy and ensuring that adequate resources are allocated to allow the organisation to achieve the goal of eliminating suicides in our patient population within agreed timescales. The Board will monitor progress of the Zero Suicide programme via its sub committees and associated governance frameworks.

4.2 **Lead Executive Director** – the lead Executive Director for this policy is the Medical Director who has strategic responsibility for the zero suicide policy and its implementation, and reporting to the trust board on all suicide related activity. The Medical Director will chair the Zero suicide Programme Board, which will oversee the delivery of the zero suicide ambition. This board will be responsible for the development of the zero suicide implementation plan as a key programme within the Centre for Perfect Care.

4.3 **Policy Lead** – Dr Rebeca Martinez, Consultant Psychiatrist and Associate Medical Director for Suicide Prevention has operational responsibility for this policy.

4.4 **Director of Patient Safety** - Responsible for supporting the clinical divisions in the post suicide (or suspected suicide) reviews as set out in the Adverse Incident Policy. This includes ensuring high quality incident reporting in the Datix system, the high level safety check at 72 hours post incident, and overseeing progress on the level 3 review. Will also lead liaison with family and carers, ensuring that the duty of candour and culture of transparency and openness are met. Responsible for quality assuring the terms of reference and management of level 3 reviews across both clinical divisions.

4.5 **Associate Medical Directors (local, secure and specialist learning disabilities divisions)** - Operational responsibility for the quality of care related to any service user with suicidal thinking or death by suicide. They provide assurance to the Medical Director that the zero suicide programme is being implemented safely and all possible interventions are used to prevent suicide. They will also be responsible for the training and management of staff who provide care and treatment to service users with suicidal thinking.

4.6 **Chief Operating Officers (local, secure and specialist learning disabilities divisions)** - Responsible for ensuring that all staff receive training about suicide prevention and follow the relevant policies. Will ensure that adequate resources are available readily as a priority to support all attempts to avoid suicide.

4.7 **Consultant Psychiatrists (Accountable Clinicians)** - It is a requirement that every service user who receives care from Mersey Care has an accountable clinician. This is the named Consultant Psychiatrist (who may in addition undertake the Mental Health Act (1983) statutory role of Responsible Clinician). With this accountability comes the overall care and treatment delivered to service users with suicidal thinking. They will meet with carers following a death by suicide, particularly after the 72 hour and level 3 reviews.

4.8 **Matrons, Ward and Team Managers** - They will ensure appropriate staff attend training in suicide prevention at both standard and advanced levels. They will also attend advanced suicide prevention training to enable them to provide supervision and guidance to staff.

4.9 **Care Co-ordinator** - They are responsible for undertaking the standard suicide prevention assessment with all service users and recognise when more advanced

assessments are required. They will seek supervision and guidance when there are any concerns regarding the presentation of service users. They will ensure that a safety plan is fully and carefully completed which reflects the service user's assessed needs in relation to the prevention of suicide.

4.10 **All qualified nursing staff** - Follow identified risk management plan and CPA documents, follow suicide prevention policy and guidance, and communicate concerns relating to a service users suicidality to the Care Co-ordinator or team manager.

4.11 **The Safe from Suicide team** - The Safe from Suicide (SfS) team led by the Associate Medical Director for Suicide Prevention will oversee the implementation of the Zero Suicide strategy and policy. The Safe from Suicide team will provide practical and expert support across the Trust, focusing on the following priority areas:

- Applying quality improvement science to this implementation programme will create new insights and provide a structure that is reliably shown to improve quality and increase value; and produce results in suicide reduction.

- The development and maximum use of a safety plan. This additional risk assessment is based upon a psychologically informed, therapeutic approach to supporting and intervening when a service user expresses ideas of self harm or suicide. Its purpose is to help identify risk and give control back to service users who are most vulnerable and thinking about self harm or suicide. The safety plan should be used at points of transitions in service and periods of high risk, including as part of safe discharge planning from in-patient services and during episodes under the Stepped Up Care team. It will be used to maintain a live database which will be monitored by the Safe from Suicide Team. Practical support to be made available to help manage risk in complex cases (discuss at next zero suicide board meeting.

- To ensure compliance with an improved standardised care pathway at high risk periods including the first 7 days after discharge from inpatient care and up to 3 months post in-patient discharge, and during periods of stepped up care and transition between different areas of service. This will include a biological, psychological and social understanding of risk factors and interventions.

- The development of a learning strategy to support the training required across the Trust to ensure all staff receive suicide prevention training regularly and based upon their role.

- Create systematic recording systems of relevant factors following suicide and near misses to enable better analysis of trends and contribution to the development of the evidence base, which will enable us to gain a better understanding of high risk groups.

- Post suicide reviews. New approaches to reviewing suicide and engaging with the bereaved will be established, learning from the Detroit experience and as part of a new study in partnership with Stanford University and Lockton insurance. This introduces a model of Communication and Resolution following a serious incident, with transparency, candour, apology and commitment to learning. All deaths by suicide will be scrutinised by the clinical divisions.

5 PROCESS/PROCEDURE

5.1 Procedure for assessing and safely managing suicidal thinking and behaviour in service users

5.1.1 Safe from Suicide care requires rigorous implementation of evidence based service interventions. The Zero Suicide approach focuses on 4 priority areas and 10 key actions as outlined in section 1 of this policy. These interventions will be the primary focus for the zero suicide programme within Mersey Care NHS Trust. They build upon existing standards and practice but with a renewed emphasis and monitoring to ensure delivery.

5.1.2 Suicide is an adverse but rare outcome, the principles that will be used to further reduce suicide rates are those of whole systems quality improvement, with specific interventions being targeted at areas of high risk for suicide within the service.

5.2 Suicide Prevention Pathway

5.2.1 For every patient who comes into contact with our services, an initial assessment should be undertaken to include a full psychosocial assessment including suicide risk assessment, risk formulation and a thorough culturally competent assessment of the person's mental state. There should be an exploration of predisposing factors ensuring an understanding of the person's specific circumstances and protected characteristics encompassing a wide perspective of that person's life.

5.2.2 Service users will have rapid access to assessment, diagnosis and treatment, following evidence based treatment pathways and protocols – with a focus on adequate treatment for mental health disorder and mitigation of risk factors including specific interventions to target alcohol abuse.

5.2.3 The treatment process is to be co-ordinated in an integrated way, ensuring that adequate information is available at transition points (eg from in-patients to community settings) including risk formulations and safety plans.

5.3 Principles for assessment of suicidal thinking and behaviours in service users

5.3.1 A full psychosocial and psychiatric assessment including suicide risk assessment and formulation is essential in service users presenting with suicidal thinking and behaviours.

5.3.2 Suicide risk assessment should occur under the following circumstances:

(a) As part of any initial assessment (first contact within a team or service, even if not first contact with Mersey Care NHS Trust)

(b) When service user, carers or staff believe that risk level may have changed

(c) When there is a change to a service user's circumstances which research indicates might lead to an elevation of risk (e.g. loss of job, loss of relationship, financial difficulty)

(d) At transition points between services or treatment settings

(e) Prior to leave and upon return from leave from in-patient settings

(f) Prior to discharge from in-patient settings and at 7-day follow-up

(g) When there is a marked observed change in service user affect (either an apparent abrupt improvement or deterioration in mood, or very high levels of anger)

(h) When there is consistent insidious low mood, resistant to treatments

5.4 Risk Formulation

5.4.1 A formulation is a clinical tool that gives clinicians an organisational framework for producing a narrative that explains the underlying mechanisms of the presenting problem and proposes a hypothesis regarding actions to facilitate change.

5.4.2 The aim of a formulation is to bring together the assessment information to develop an understanding of the target behaviour (in this case suicidal behaviour), so as to inform and direct treatment and management plans.

5.4.3 Risk formulations provide a crucial link between assessment and management. A formulation should be made based on risk factors and all other items of history and mental state. It should specify factors likely to increase the risk of suicidal behaviour and those likely to decrease it.

5.4.4 Suicidal ideation or attempts are indicators of intolerable levels of distress, hopelessness or helplessness. Formulation of risk should seek to establish any clinical reasons behind increased risk, in order for this to be incorporated into treatment plans.

5.4.5 A risk formulation will consist of:

(a) **Description of the risk (Problem)**: Be explicit. What exactly is the risk related to attempting suicide (method, means, intent).

(b) **Predisposing factors**:. There should be an exploration of predisposing factors ensuring an understanding of the person's specific circumstances

and protected characteristics encompassing a wide perspective of that person's life. Evidence based factors within the service user's characteristics and presentation which elevate the risk are to be considered e.g. previous history of overdose, diagnosis of emotionally unstable personality disorder

(c) **Precipitating or trigger factors**: Specific situational or personal factors which have lead to increased suicide risk. Identified from previous suicide attempts and from discussion with service user and carers regarding current triggers. e.g. feeling let down by support services, financial difficulties

(d) **Perpetuating factors**: Longer term, more stable factors which tend to keep the risk of suicide going e.g. alcohol dependence, social isolation

(e) **Protective factors**: Any factors which protect against suicidal acts. e.g. positive relationship with partner, good engagement with crisis services.

5.4.6 It is important to note that suicidal thoughts alone do not always equate to risk of suicide. Generally, risk increases as a person moves from thoughts to intention to making plans. Concrete plans indicate a high risk.

5.4.7 Practitioners should be guided by the CPA risk assessment documentation prompts, alongside their own service-based assessment practices.

5.5 Principles for management of suicidal thinking and behaviours in service users

5.5.1 If a patient is assessed to be high risk of suicide, then the management plan should be guided by the risk formulation focusing on:

(a) Adequate assessment and treatment of underlying condition (bio-psycho-social approach)
(b) Removal of access to means
(c) Modification of risk factors

5.5.2 Evidence based treatment guidelines should be used for patients with diagnosed mental health disorders (NICE guidelines).

5.5.3 There should be continued and regular assessment of risk.

5.5.4 Clinical review of response to treatment should be carried out at regular intervals. If no improvement, review of treatment plan to be considered, including:

(a) Compliance/ concordance with current medication
(b) Level of support
(c) Psychosocial interventions
(d) Role of drugs and alcohol
(e) Consider review of diagnosis and treatment plan
(f) Take into account precipitating and maintaining risk factors

5.5.5 For in-patients care:

(a) Pre-leave assessments to be carried out including a suicide risk assessment and mental state at the time of leave and on return from leave.
(b) Level of observations required whilst on the in-patient unit depending on level of risk and environmental factors

5.5.6 Transition points within different areas of service present higher risk for suicide for the service user, and more specifically the 3-month post in-patient discharge period.

5.5.7 A standardised care pathway at high risk periods including the first 7 days after discharge from inpatient care and up to 3 months post in-patient discharge, and during periods of stepped up care and transition between different areas of service will be implemented. This will include a biological, psychological and social understanding of risk factors and interventions.

5.5.8 Safety plans should be used at points of transitions in service and periods of high risk, including as part of safe discharge planning from in-patient services and during episodes under the Stepped Up Care team.. This additional risk assessment is based upon a psychologically informed, therapeutic approach to supporting and intervening when a service user expresses ideas of self harm or suicide. Its purpose is to help identify risk and give control back to service users who are most vulnerable and thinking about self harm or suicide. The safety plan will be delivered within an appropriate format for that person.

5.6 **Managing deaths by suicide**

5.6.1 All deaths are distressing and the bereavement caused by suicide may be complicated due to the traumatic circumstances surrounding the suicide. Family members, partners, friends, health professionals may all be affected by a suicide death. People bereaved by suicide are themselves at higher risk of suicide.

5.6.2 The effective management of a death and the support provided to their families is of primary importance and can help all those involved gain resolution and come to terms with their loss in a safe and natural way.

5.6.3 All staff, patients and families/carers affected by a suicide, or a serious suicide attempt, will be given prompt and open information about the incident, if known, and the opportunity to receive appropriate and effective support as soon as they require it.

5.6.4 A family liaison worker will be allocated to engage with the family of the deceased to provide support and information about relevant support groups and organisations. The family liaison worker will also maintain contact with the family/carers throughout the period of any internal investigation and be the first point of contact with the organisation. Support will be offered in a culturally sensitive way to that person.

5.6.5 Health professionals affected by the suicide of a service user will be supported by their line managers and always offered the opportunity to self refer to staff support services. Service managers must ensure that all staff involved in a service users

care are made aware of the death and offered the same support. Staff support will provide an initial telephone triage consultation within 48 hours of a referral being made and prioritisation for follow up appointments for those involved in a suicide.

5.6.6 The Death of a Service User Policy (SD02) also provides guidance for the management of a suicide in certain settings.

5.7 **Post incident reviews**

5.7.1 A review of every suicide death will take place with the main aim being to look at the care and treatment the person was receiving prior to his or her death and to see what lessons can be learned in order to help reduce the risk of future suicides. These reviews are not fault finding investigations but will assist clinical services to review existing suicide prevention protocols.

5.7.2 Post incident reviews will be standardised to favour learning and collection of relevant data. Data will be collected, analysed and disseminated on suicides and serious suicide attempts to enhance opportunities for learning.

5.7.3 New approaches to reviewing suicide and engaging with the bereaved will be established. This will introduce a model of Communication and Resolution following a serious incident, with transparency, candour, apology and commitment to learning. All deaths by suicide will be reviewed by the clinical divisions and include staff independent of the service involved in the persons care.

5.7.4 Whilst there are national guidelines regarding timescales for completing serious incident reviews it is our intention to ensure all post suicide reviews are completed within four weeks. Learning will be shared across all clinical services immediately following validation including a post-incident review process to promote reflective team learning practice.

5.7.5 The Safe from Suicide Team will identify staff to undertake post suicide reviews, thus building up expertise and availability.

6 CONSULTATION

6.1 This policy has been widely consulted upon across all divisions and professional groups, individuals and groups include:

(a) Zero Suicide Programme Board

(b) Health & Safety Committee

(c) The local, secure and specialist learning disabilities divisional boards

(d) Centre for Perfect Care sub-committee

7 TRAINING AND SUPPORT

7.1 Development of competency based suicide prevention training for all staff appropriate for their level and role within the organisation. The enhanced model will incorporate three levels of training for staff across Mersey Care.

7.2 The Safe from Suicide team will take responsibility for ensuring the training is fit for purpose and reviewed yearly. There will be an emphasis on learning from adverse incidents, and closing the learning loop following a post suicide review. There will be a central record of staff training which will be monitored by the SfS team.

7.3 Service users and carers will be involved in the planning and delivery of training for staff.

7.4 The model will be:

	Content	Assessment
Level 1 **All staff** **Mandatory** **E-Learning** **1-2 hours annually**	**Suicide awareness and alertness** • Increase awareness suicide and risks • personal and societal attitudes about suicide • Identifying thoughts of suicide • Suicide prevention resources • Culturally competent understanding	Completing of the module Reviewing in PACE session
Level 2 **All Clinical staff group** **Face-to-Face team based approach** **½ day annually**	**Suicide Prevention training** • Clinically orientated training • Focus on working with people at risk of suicide • Discussing suicide with people • Terminology • formulation • Skills development when someone is at risk of suicide • Identifying risks and developing a safety plan • Support and resources available • Recognition that suicide interventions / preventions is broader than when someone is at an acute risk - explore self management, resilience, working with families etc	Competency based assessment undertaken by Level 3 practitioner
Level 3 **All ward / community mangers** **Face-to-Face Classroom Based** **1 day + additional support and training during the year**	**Suicide Prevention Leadership and Training** • Leadership and 'training the trainer' skills • **Enhanced training on:** o Skills development when someone is at risk of suicide o Identifying risks and developing a safety plan o Support and resources available o Recognition that suicide interventions / preventions is broader than when someone is at an acute risk - explore self management, resilience, working with families etc • Learning and reviewing post incident reviews • Developing a suicide prevention network • Research and innovation	Observation of training sessions - peer review

8 MONITORING

8.1 The policy will be monitored by:

Safe from Suicide Team

The Safe from Suicide Team will provide updates and a written progress report on a quarterly basis. The monitoring of each of the zero suicide projects will be led by the Rebeca Martinez, Associate Medical Director for Suicide Prevention.

Centre for Perfect Care Sub-committee
A written zero suicide progress report will be presented to the Centre for Perfect Care Sub-Committee on a quarterly basis.

9 SUPPORTING DOCUMENTS

9.1 This policy and guidance should be considered in conjunction with other Mersey Care Policies. (refer to Section 10.4)

9.2 In line with national policies and guidelines there is a requirement that Mersey Care should provide high quality care for the suicidal service user and their family.

9.3 This will entail comprehensive assessment, formulation and management of the individual service user, including a psychologically informed safety plan. Liaison with appropriate individuals and services, staff training, management of the physical environment, giving advice on wider ranging public health risk reduction when possible, and a positive service culture surrounding the ability to reduce suicide and how to help those at risk.

9.4 This document is compliant with SA01: Development, ratification, distribution and review of policies and procedures.

List of Supporting Documents

Ref No	Name
SA2	Effective Management of Risk
SA3	Reporting, management and review of adverse incidents
SA10	Use of clinical risk assessment tools
SD01	Leave for an informal inpatient
SD04	Management of clinical risk through supportive observation
SD19	Advance statements
SD21	Care Programme Approach
MC02	Assessment of Capacity

9.5 The following reference documents should be considered in conjunction with this policy document:

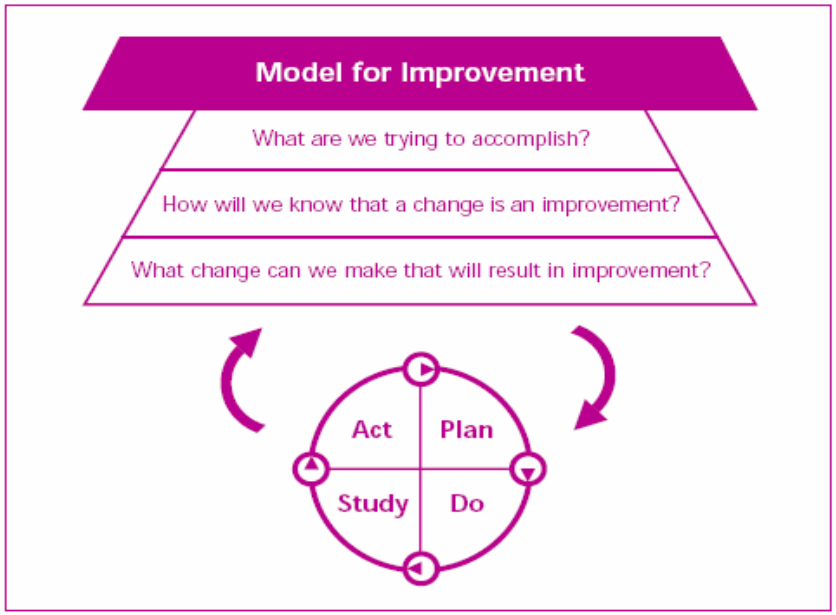
(a) Suicide prevention learning strategy
(b) Safety plans and practitioner's guide

Appendix A

IMLEMENTATION PLAN FOR: Zero Suicide

	Issues identified / Action to be taken	Lead	Time-Scale
1. Co-ordination of implementation • The implementation of the zero suicide strategy and policy will be co-ordinated and monitored by the Safe from Suicide team • Safe from Suicide team priorities are: - Development and use of the safety plan - Compliance with an improved standardised care pathway - Development of a learning strategy - Creation of a systematic recording system - Post suicide reviews • The Safe from Suicide team will report quarterly to the Zero Suicide programme Board	1. Safe from Suicide team membership to be identified, with representatives from across local and secure division	Rebeca Martinez	Reviewed monthly by the Safe from Suicide team
2. Engaging staff Staff engagement will take place at both programme and project level - Local and secure staff will be members of the Safe from Suicide team and Programme Board - Local and secure staff to be identified as part of the zero suicide training team, as detailed in the zero suicide training strategy - All projects connected to the zero suicide driver diagram will establish key members of staff to drive the project forward, including project lead, clinical leads/staff group, information/IT staff	1. Zero suicide training team membership to be identified, with representatives from across local and secure division 2. Project membership to be reviewed to ensure representatives included are able to influence the implementation of each project	Safe from Suicide team	Reviewed monthly by the Safe from Suicide team

3. Involving service users and carers • Service users and carer engagement will take place both at programme and project level - Service user and carer representation as members of the Safe from Suicide team and Programme Board - Service user and carer involvement in both the design and delivery of the zero suicide training team, as detailed in the zero suicide training strategy - All projects connected to the zero suicide driver diagram will consider service user and carer involvement in a number of ways; project group, co-production of projects, focus groups/on-to-one interviews, evaluation, forums	1. Service user and carer membership to be identified at programme and project level 2. Level of involvement and support mechanism to be developed	Safe from Suicide team	Reviewed monthly by the Safe from Suicide team
4. Communicating • The Zero Suicide strategy, policy and implementation plan alongside specific project updates will be launched at the Perfect Care launch day in September • Further communication will be lead by the Safe from Suicide team • The Perfect Care SharePoint site will be a resource for information and sharing of progress	1. Arrangements for the Perfect Care launch to be finalised 2. Perfect Care SharePoint site 3. PPerfect Care Dashboard in development	Safe from Suicide team	September 2015
5. Resources • *Suicide Prevention Clinical Lead appointed to support delivery of the programme*	1. Post in place	Safe from Suicide team	Post funded for 2 years

6. Securing and sustaining change • Quality improvement science will be applied to the zero suicide strategy and aligned projects to ensure a robust and credible implementation plan is implemented. The quality improvement methodology will provide the framework for developing, testing, implementing and reliably evaluating change that will lead to improvements • The model for improvement tests and measures small scale change before large scale change is accelerated through the Trust  Reference: Langley G, Nolan K, Nolan T, Norman C, Provost L, (1996), The Improvement Guide: a practical approach to enhancing organisational performance, Jossey Bass Publishers, San Francisco.	1. Safe from Suicide team will support, review and monitor the implementation of the projects aligned to the zero suicide strategy and policy	Safe from Suicide team	Reviewed monthly by the Safe from Suicide team

7. Evaluating • A number of outcome measures have been identified. The measures will identify if the changes being implemented have led to improvements across the four priority areas: - Service user and partner engagement - Safe and effective care and treatment - Competent workforce - Research and evaluation • A further extensive external evaluation will be undertaken by Professor Louis Appleby's team at Manchester University	1. Safe from Suicide Team in conjunction with Manchester university	Safe from suicide team Centre for Perfect Care Sub-Committee	Reviewed monthly by the Safe from Suicide team Reviewed quarterly by the Zero Suicide programme board

Equality and Human Rights Analysis

Title: SD38 Zero Suicide Policy
Area covered: All of the Trust

What are the intended outcomes of this work?
This policy was subject to the equality and Human Rights assessment in September 2015.
This assessment was completed 17/10/2016.

There have been some minor additions to the policy. The Triangle of Care has been incorporated to take account off service users, carers and family .

> **Action 1 - Co-production of materials and information with service users, carers and family members to support self-care, and following the principles of the Triangle of Care. A variety of formats appropriate to the person are available.**

Mersey Care takes the view that suicide should be regarded as an avoidable death, which is both preventable and amenable to care.
This policy has been developed to improve the care provided and the outcomes for people at risk of suicide under the care of Mersey Care NHS Trust.
The policy sets out the standards of care that will be offered to all service users who express suicidal ideas to ensure that they have The highest quality assessment, support and treatment until they are recovered.
This approach has ben inspired by the pioneering work within the Henry Ford Hospital system and was developed by philosophy and practice of ‘perfect depression care’ which led in four years to a 75%

drop in suicides.
Who will be affected? Service users/patients using the Trust services. Staff implementing the new approach.

Evidence
What evidence have you considered? The policy.
Disability inc. learning disability This policy relates to mental health with the aim of reducing suicide rates. It is estimated that 27% of suicides occur while the person is under the care of specialist mental health team. These people will be the focus for Mersey Care NHS Trust as they are highest risk and amenable to our care.
Sex The policy takes account of public health data in relation to gender issues and men in particular. Approximately 1 million people die each year across the world and approximately 6,000 in the UK. It is estimated that 75% are men and the leading cause of death under the age of 50. Indicators
Race **Additions added to take account of culture.** 1. Psychologically- informed risk formulations and safety plans will be implemented as a therapeutic intervention to help identify risk and protective factors, within a culturally competent framework. Collaborative work with the patient to promote recovery work and future self-management strategy. 2. A family liaison worker will be allocated to engage with the family of the deceased to provide support and information about relevant support groups and organisations. The family liaison worker will also

maintain contact with the family/carers throughout the period of any internal investigation and be the first point of contact with the organisation. Support will be offered in a culturally sensitive way to that person.
Age It is estimated that 75% are men and the leading cause of death under the age of 50.
Gender reassignment (including transgender) No issues identified within the discussions.
Sexual orientation Need to consider lgbt data - indicators
Religion or belief No issues identified within the discussions.
Pregnancy and maternity No issues identified within the discussions.
Carers Co-production of materials and information with service users, carers and family members to support self-care, and following the principles of the Triangle of Care. A variety of formats appropriate to the person are available.
Other identified groups No issues identified within the discussions.
Cross cutting **Within the Suicide Prevention Pathway the following had been added:** 9.5.2 **For every patient who comes into contact with our services, an initial assessment should be undertaken to include a full psychosocial assessment including suicide risk assessment, risk formulation and a thorough culturally competent assessment of the person's mental state. There should be an exploration of predisposing factors ensuring an**

understanding of the person's specific circumstances and protected characteristics encompassing a wide perspective of that person's life.

This policy should have a positive impact across all groups.

Human Rights	Is there an impact? How this right could be protected?
This section must not be left blank. If the Article is not engaged then this must be stated.	
Right to life (Article 2)	Human Rights Based Approach Supported. The overall aim of the policy is reduce deaths due to suicides.
Right of freedom from inhuman and degrading treatment (Article 3)	Human Rights based approach supported.
Right to liberty (Article 5)	No issues identified in discussions.
Right to a fair trial (Article 6)	No issues identified in discussions.
Right to private and family life (Article 8)	No issues identified in discussions.
Right of freedom of religion or belief (Article 9)	No issues identified in discussions.
	No issues identified in

Right to freedom of expression Note: this does not include insulting language such as racism (Article 10)	discussions.
Right freedom from discrimination (Article 14)	No issues identified in discussions.

Engagement and involvement

Service user and partner engagement :

1. Co production with service users of materials and resources to aid self care.
2. Collaboration with primary care, Emergency department's clinical teams and Police to ensure effective joint approach taken at critical points.

Summary of Analysis

Eliminate discrimination, harassment and victimisation

Public health data highlights that mental health is an area with identified inequalities and this needs to addressed.
It is estimated that 27% of suicides occur while the person is under the care of specialist mental health team. Mersey Care NHS Trust will focus on people under our care as they are highest risk and amenable to our care.

What is the overall impact?
This policy has been produced with the aim of reducing suicide for all users of the Trust services. Impact is intended to be positive.

Addressing the impact on equalities
See full action plan in appendix A of the policy.

Action planning for improvement
Full action plan has been developed.

For the record
Name of persons who carried out this assessment (Min of 3):
Review

1. George Sullivan
2. Dr Rebecca Martinez

Date assessment completed:
17.10.2016

Name of responsible Director: Medical Director

Date assessment was signed:10.10.2016

Action plan template

This part of the template is to help you develop your action plan. You might want to change the categories in the first column to reflect the actions needed for your policy.

Category	Actions	Target date	Person responsible and their Directorate
Data collection and evidencing	A full implementation plan has been developed. See appendix A of the Policy for full details.		
Analysis of evidence and assessment	A full implementation plan has been developed. See appendix A of the Policy for full details.		
Monitoring, evaluating and reviewing	• A number of outcome measures have been identified. The measures will identify if the changes being implemented have led to improvements across the four priority areas: - Service user and partner	On going.	Zero Suicide programme Board

	engagement - Safe and effective care and treatment - Competent workforce - Research and evaluation • An further extensive external evaluation will be undertaken by Professor Louis Appleby's team at Manchester University .		
Transparency (including publication)	Policy to be placed on Trust website along with this equality and human rights analysis.		