Pennine Care NHS
NHS Foundation Trust

Policy Document Control Page

Title: Suicide Prevention Strategy

Version: 7

Reference Number: CL50

Keywords:
(please enter tags/words that are associated to this policy)
Suicide Prevention Self Harm

Supersedes

Supersedes: 6

Description of Amendment(s): Information sharing and suicide prevention Consensus statement page 7. Suicide Prevention concept and practice proposition page 6. Minor edits. Reformatted. Paragraphs numbered. Related policies section added. Date range changed (2016-18).

Originator

Originated By: Matt Walsh

Designation: Patient Safety Manager

Equality Impact Assessment (EIA) Process

Equality Relevance Assessment Undertaken by: Matt Walsh

ERA undertaken on: 11th May 2016
ERA approved by EIA Work group on:

Where policy deemed relevant to equality-

EIA undertaken by Matt Walsh

EIA undertaken on: 11th May 2016
EIA approved by EIA work group on:

Approval and Ratification

Referred for approval by: Matt Walsh

Date of Referral: 16th May 2016

Approved by: SP&SH Group Chair

Approval Date: 11th May 2016

Date Ratified by Executive Directors : 16th May 2016

Executive Director Lead: Medical Director

Circulation

Issue Date: 17th May 2016

Circulated by: Performance and Information

Issued to: An e-copy of this policy is sent to all wards and departments

Policy to be uploaded to the Trust's External Website? YES

Review

Review Date: January 2017

Responsibility of: Matt Walsh

Designation: Patient Safety Manager

This policy is to be disseminated to all relevant staff.

This policy must be posted on the Intranet.

Date Posted: 16th May 2016

Pennine Care NHS
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SUICIDE PREVENTION STRATEGY

2016 - 2018

1. Introduction

1.1 The Suicide Prevention Strategy for England was published by the Department of Health in 2002 to support the Saving Lives: Our Healthier Nation target was to reduce the death rate from suicide by at least 20% by 2010.

1.2 This National Strategy followed a number of studies, recommendations and policies, which highlighted the need for a cohesive and systematic approach to reducing suicide. These included:

- National Service Framework for Mental Health (MHNSF): Standard 7
- Safety First: Five-Year Report by the National Confidential Inquiry Suicide Prevention Toolkit
- Making It Happen: A Guide to Delivering Mental Health Promotion
- National Service Framework for Older People
- Managing Deliberate Self-Harm in Young People, Royal College of Psychiatrists Council Report.

1.3 Previous National Suicide Prevention Strategies for England laid out all the actions that would be required, at a national level, to reduce suicide in England according to 6 goals. More recent publication in July 2012 has also included the following 6 goals:

- **Goal 1: Reduce Suicides in High-Risk Groups**
- **Goal 2: Promote Mental Health Wellbeing in the Wider Population**
- **Goal 3: Reduce Access to Means**
- **Goal 4: Improve Media Reporting of Suicide**
- **Goal 5: Promote Research on Suicide Prevention**
- **Goal 6: Improve monitoring of Progress**.

1.4 In December 2006 the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) published Avoidable Deaths; five year report of the national confidential inquiry into suicide and homicide by people with mental illness. This report highlighted continuing concerns in the following areas:

- Inpatients dying by suicide whilst being off the ward without permission
- The transition from inpatient to community care
- The management of risk and risk assessment.

1.5 The same concerns were also highlighted in the more recent report of NCISH published in 2012. In 2013 the government made clear its commitment to suicide prevention with the publishing a new cross-government strategy for England. This drew on the experience of the first suicide prevention strategy published a decade earlier. In 2007 suicide had fallen to the lowest rate in 150 years and there had been a marked fall in suicide in young men. Suicide in mental health inpatients had almost halved since 1997 and deaths had also fallen among prisoners. Sadly since 2007, there have been signs that the

suicide rate has risen in England as it has in many countries and the National Confidential Inquiry annual report shows a rise in overall patient suicide. It identifies that whilst in-patient suicide continues to fall there are twice as many suicides under crisis resolution/home treatment compared to in-patients.

1.6 The NCISH Report published in July 2015 provides new data on suicide prevalence and the challenges for services. There continues to be a steady rise in the number of male patients aged 45-54 (73% increases since 2006) who are completing suicide. It also reports that 40% of suicides are completed during or within days of discharge from acute care with the greatest rise being seen in Home Treatment or Crisis teams.

1.7 Pennine Care NHS Foundation Trust suicide prevention strategy will take account of the above findings and ensure that it takes this into its future development work.

2. Preventing Suicide

2.1 Pennine Care NHS Foundation Trust has now adopted the 'National Patient Safety Agency Preventing Suicide: A toolkit for mental health services, 2009' Annual Audit standards to develop a Trust wide Suicide Prevention Framework. This will support Pennine Care to:

- Establish an Audit
- Identify risks and measure performance against NPSA standards
- Support the development of local suicide prevention strategies
- Produce data that could be merged at regional and national levels to identify trends for further shared learning.

2.2 The NPSA toolkit for suicide prevention identifies eight standards that reflect the changes in practice that have occurred in mental health. Pennine Care has included in its strategy the eight standards that will provide a method of measuring the level of care provided to patients at risk of suicide and self harm and a view of the level of adherence to suicide prevention standards that will in turn inform the annual work plan. In addition the National Confidential Inquiry into Suicide and Homicide has made recommendations for clinical services over a number of years. They have identified quality statements regarding clinical, organisational and training aspects of care that have also been included in the standards that will inform the annual work plan and clinical audits.

2.3 Existing governance arrangements in place will support the suicide prevention strategy these include:

1. The Suicide Prevention Lead for the Trust is in place. This is the role of Patient Safety Lead, supported by the Medical Director

2. A Suicide Prevention & Self Harm Working Group meets bi monthly with multi-disciplinary representation from all areas of the Trust. Members of the Trust Group, include leads from Local Borough Services.

3. Members of the Working Group have responsibility for contributing to the Trust wide strategy and for feeding back on local actions and targets

4. The Working Group identifies where suicide prevention activity can be located within relevant policy/strategy within the organisation and partner agencies

5. Suicide Prevention Leads are identified to consult on strategy within key organisations and feedback to the Working Group

6. The strategy is developed with key objectives for each goal and proposed responsibility for action. The strategy has been circulated widely for consultation across the Trust

7. The strategy has been developed with an agreed implementation plan, action points and timescales (see Appendix 2)

8. The aim of the strategy is to integrate suicide prevention into key policy and practice across the Trust.

9. Pennine Care NHS Foundation Trust is undertaking continuous audit of the implementation of the Suicide Prevention Standards, based on the National Patient Safety Agency Preventing Suicide: A Toolkit for Mental Health Services, 2009

1. Pennine Care NHS Foundation Trust will contribute to on-going evaluating and monitoring by local boroughs and Greater Manchester Suicide Prevention Network.

3. Specialist Mental Health Provider Services

3.1 Pennine Care is responsible for implementing the Safer Services guidance and for ensuring that local Mental Health Services are delivering effective Care Programme Approach (CPA), post-discharge follow up, safe environments and Serious Untoward Incident Reviews. Mental Health Services are also an invaluable source of information, skills, knowledge and expertise in risk assessment, audit, interventions and integrated working, which can be shared with other agencies.

3.2 The Patient Safety Improvement Group scrutinises team investigation reports to ensure that the required standards of care have been implemented when incidents of serious self harm or suspected suicide have occurred.

3.3 In addition recommendations from National Confidential Enquiry Reports will inform the annual work plan.

3.4 Other agencies lead on specific aspects of suicide prevention:

- Local Strategic Partnerships (LSP's)
- Police and Transport Police
- Independent Sector (Private and Voluntary Organisations)
- Criminal Justice System
- Coroner's Office
- Service User Groups and Families.

4. Suicide Prevention Practice Proposition

4.1 The Trust has agreed to a commitment to a culture of adopting the concept and practice proposition that suicide deaths for people under the care of mental health services are preventable. This concept requires tangible support in a safe blame free environment focusing on systems rather than individual blame and considers the following key areas to be fundamental in it's success.

4.2 A Competent workforce

4.2.1 Staff must be confident in their ability to engage and help those clients who are thinking about suicide and be able to ask the question "Are you thinking about taking your life"

4.2.2 Specific training is required in the following

- Engagement
- Assessing risk of suicide and identification of protective factors
- Formulation of a risk summary to inform the choice of interventions
- Treatment of suicide risk including lethal means restriction
- Safety planning

4.3 Standardised Risk Assessments

4.3.1 Assessing for suicide risk should include the person's intent, plans, means, availability, presence of acute factors, history of suicide attempts and dug and alcohol use. (Please see Clinical Risk Assessment Policy). This applies whether PCFT staff are using an electronic patient record or a paper record. The key to providing a safe continuity of care is for staff to share their assessment of risk with any other part of the service that is taking over the care of the patient.

4.4 Suicide Interventions

4.4.1 With the level of risk established the next step is to determine the most appropriate care environment available to address risk and care needs. Newer models of care suggest that treatment and support of person's suicide risk should be carried out in the least restrictive setting and designed to keep a suicidal person out of hospital if at all possible. Suicide interventions should target suicidal thinking and behaviour directly. Safety planning also

sometimes called crisis response plans should be developed in collaboration with the service user and their families where appropriate identifying a list of coping strategies and sources of support. The plan should be brief and in the service users own words and include a plan to restrict access to lethal means such as limiting access to medication Please see guidance for staff on removing the patient's access to the means of completing suicide at Appendix 1.

4.4.2 The role and involvement of family members or friends should be considered within the safety plan where appropriate. Research from the NCISH (July 2015) indicates that around 14% of people may have been prevented from completing suicide had there been a greater involvement of family or carers.

4.4.3 The Trust has obtained the *Help is at Hand* booklets for those bereaved by suicide and will be shared with families post suspected suicide. The Trust also has information leaflets for both service users and their carers *on keeping safe* that can support the crisis management plan. These can be obtained from your Governance department.

4.5 Problem solving therapies

4.5.1 Research has shown that suicidal individuals have specific deficits in problem solving and thinking through their situation. Research has also shown that use of problem solving therapies such as Cognitive Behaviour Therapy is effective treatment for suicidal individuals.

4.6 Access to follow up services

4.6.1 Access to follow up following discharge from services is critical. This could include access to crisis hotlines and tele counselling which provide an alternative to emergency departments.

4.6.2 Consideration about contact with service users during the period that they are on a waiting list for therapy should also be considered and implemented where clinically indicated.

4.6.3 The Trust will be looking at an integrated system with external partner agencies to improve follow up for service users following discharge from services.

4.7 National Suicide Prevention Strategy

4.7.1 Suicide prevention is also covered in the cross governments framework 'No health without mental health' developed jointly by the Department of Health, the NHS Confederations Mental Health Network, Mind, Rethink Mental illness, Turning Point and Centre for Mental Health. The framework sets out a number of objectives for mental health providers, these include:

- **Ensure equality of access and outcomes** by measuring activity and outcomes aggregated by Equality Act characteristics

- **Assess and improve service user and carer experience** including development of structures to obtain continual feedback and how this supports continuous service improvement
- **Ensure service design is based on humanity, dignity and respect** that create and organisational culture based on service user engagement and co-production. In addition recommendations from CQCs Mental Health Act, Mental Capacity Act and Deprivation of Liberty Safeguards monitoring are acted upon
- **Keep people safe** remaining vigilant and continuing to strengthen clinical practice, risk management, and continuity of care so that people are protected from the risk of suicide
- **Improve the physical health and wellbeing of people with mental health problems** which might include smoking cessation, weight management, and drug and alcohol misuse, in addition the integration of physical health into decisions about prescribing and monitoring of medication
- **Improve the mental health and well being** of people with long term physical conditions such as talking therapies
- **Consider the power of information to transform services** innovative use of information which will be essential in implementing the mental health strategy
- **Focus on choice, recovery and personalisation** considering how service users perceptions of recovery can be incorporated into all elements of clinical practice and ensuring people have appropriate support and access to advice and information.
  This could include advice on housing, benefits, debt, training and education, access to personal health budgets. Enabling choice includes joint planning with service users, including crisis management planning, providing choices of treatment and medication based on available evidence, including offering a wider range of talking therapies in acute in-patient services
- **Developing protocols for sharing information with carers,** including working with primary care to determine how best to act on information regarding potential crisis, as well as developing staff capability to agree appropriate confidentiality and information sharing agreements
- **Tackle stigma and discrimination.** Inspiring a culture where discrimination has no place and stigma is actively challenged.

5. Information sharing and suicide prevention: Consensus statement

5.1 Confidentiality, consent and capacity are all issues which have rightly received a great deal of careful attention over the years. There are clearly times in dealing with a person at risk of suicide when practitioners will need to consider informing the family and friends about aspects of risk and may need to create a channel of communication for both giving and receiving information that will help keep the person safe.

5.2 In line with good practice, practitioners should routinely confirm with people whether and how they wish their family and friends to be involved in their care

generally, and when looking at information sharing and risk in particular. In order to assist practitioners to respect people's wishes, wherever possible, the person's view on who they would wish to be involved – and potentially, who they would wish not to be involved - if there is serious concern over suicide risk, should have been discussed and recorded. Many service users when well and not actively feeling suicidal will be able to rationally discuss the safety remit of services contacting families in times of crisis to preserve life; services should routinely ensure that these opportunities are not missed with carers and families. A good risk management plan and safety plan is only effective at the point of crisis and services must know the implementation process when crises arise for patients.

5.3 In cases where these discussions have not happened in advance, a practitioner may need to assess whether the person, at least at that time, lacks the capacity to consent to information about their suicide risk being shared. The Mental Capacity Act makes it clear that a person must be assumed to have capacity unless it is established that they lack capacity, and that a person is not to be treated as unable to make a decision merely because they make an unwise decision.

5.4 However, if a person is at imminent risk of suicide there may well be sufficient doubts about their mental capacity at that time. In these circumstances, a professional judgement will need to be made, based on an understanding of the person and what would be in their best interest. This should take into account the person's previously expressed wishes and views in relation to sharing information with families, and, where practical, include consultation with colleagues. The judgement may be that it is right to share critical information if this is to save someone's life.

5.5 If the purpose of the disclosure is to prevent a person who lacks capacity from serious harm, there is an expectation that practitioners will disclose relevant confidential information, if it is considered to be in the person's best interest to do so. Disclosure may also be in the public interest because of the far-reaching impact that a suicide can have on others. For example the method of suicide could cause potential serious harm to others. The practitioner will need to make a judgement about whether the benefits to an individual or society in disclosing information without consent outweigh both the individual's and the public interest in keeping it confidential. Determining where to draw the line is a matter for professional judgement in each individual case.

5.6 The urgency of the need for disclosure will also be relevant to the judgement. The immediacy of the suicide risk will be affected by the degree of planning a person has done, the type of suicide method planned or already attempted, and circumstances such as being left alone, refusing treatment, drinking heavily or drug use.

5.7 It is also clear that the duty of confidentiality is not a justification for not listening to the views of family members and friends, who may offer insight into the individual's state of mind which can aid care and treatment. Good

practice will also include providing families with non-person specific information in their own right, such as how to access services in a crisis, and support services for carers.

5.8 Sharing information within and between agencies can also help to manage suicide risk. It is therefore important for practitioners to consider discussing cases with colleagues or seeking advice from legal teams, a professional association or regulatory body if they are unsure whether information should be shared, rather than simply withholding it. If possible, this should be done without revealing the person's identity. **The duty of patient's confidentiality should not be allowed to outweigh the chance of saving someone's life**. The Patient Safety lead and Medical Director would support the outcome of a life saved over and above the breach of patient confidentiality.

5.9 Obtaining information from and listening to the concerns of families are key factors in determining risk. However some people do not wish to share information about themselves or their care. Practitioners should therefore discuss with people how they wish information to be shared, and with whom. Wherever possible, this should include what should happen if there is serious concern over suicide risk and the risk management plan and safety plan must contain an alternative in the absence of consent to contact carers or families.

5.10 It is important that the practitioner records their decision about sharing information on each occasion and the justification for this decision. Even where a person wishes particular information not to be shared, this does not prevent practitioners from listening to the views of family members, or prevent them from providing general information such as how to access services in a crisis.

6. Implementation of the Strategy

6.1 Implementation will be via an annual work plan. This will be monitored by the Suicide Prevention & Self Harm Working Group on a bi monthly basis and reviewed on an annual basis. See Appendix 2.

7. Related policies

- Disclosure/Discovery and Assisted Suicide Policy (CL99)
- Clinical Risk Assessment & Management Policy (CL19)
- Incident Reporting, Management & Investigation Policy (CO10)

Appendix 1

GUIDANCE FOR MENTAL HEALTH SERVICES REMOVING THE MEANS OF SUICIDE AND REDUCING RISK

"Means reduction" (reducing a suicidal person's access to highly lethal means) is an important part of a comprehensive approach to suicide prevention. It is based on the following understandings. Intent is not all that determines whether an attempter lives or dies; means also matter.

Reducing access to lethal means saves lives. Means reduction doesn't change the underlying suicidal impulse or necessarily reduce attempts; rather, it saves lives by reducing the lethality of attempts. Hanging is the most common method of suicide followed by overdose.

Where service users are identified at risk of serious self-harm/ suicide or disclose recent or future plans on methods of suicide, staff must consider the following to reduce the risk;

Safety is a priority for the service user, especially if recovering from a suicide attempt and whilst safety is ultimately an individual's responsibility, a person who feels suicidal may have a difficult time making choices.

Where service users have disclosed they have in their possession the means to enact suicide, such as a recent purchase of a rope and it is apparent that there has been a degree of planning for their suicide, staff should make every effort to remove lethal means. This would include items such as:

- **Ropes**
- **Excess medication**
- **Medicines such as Paracetamol and Opiate-based medications (including excessive amounts but leaving enough for daily therapeutic doses)**
- **Sharp knives**

It is unacceptable to not remove lethal means if it is safe to do so and the person has expressed intent to end their life by use of the lethal means. Pennine Care staff must seek support and advice from line management, Patient Safety Lead or senior management team if in doubt about the legality of removing lethal means.

Consideration should be given to safer prescribing where risk exists.

Other methods of suicide which may be personal to the service user may be disclosed, and it would be justifiable for staff to intervene in removing the potential means. It should be explained to the service user, that you are temporarily removing the items and these will be returned when the risk has reduced.

When a service user takes active steps in the presence of staff, or informs staff of their intent to harm themselves, where the consequences could end in death an immediate crisis plan should be enacted.

When staff are present the use of reasonable physical intervention, is justifiable to effect the safe removal of items when a service user attempts to harm themselves. However your own personal safety is paramount and must be considered and staff should simultaneously request assistance from emergency services by dialling 999.

Where the use of firearms is disclosed as a method, if after assessment staff judge that the patient has access to a firearm and express intent to use it staff MUST contact the police immediately before attending the property and must not enter without police support. If already in the presence of a service user who discloses about firearms, if after assessment staff judge that the patient has access to a firearm and the intent to use it, staff must seek advice from the police immediately by ringing 999. Staff must vacate the property if at any time they feel that they are in danger of harm themselves. All incidences where actual firearms are in evidence must be reported to the Trust's Security Management Service Manager.

APPENDIX 2

Suicide Prevention Action Plan 2016 - 18

Standard:	Criteria	Procedure	Action	Lead	Completion Date
1. Appropriate Level of Care	a) The Trust has an up to date CPA Policy	CPA Policy reviewed 2 yearly as part of the CPA audit and monitoring and review group Annual audit of CPA Policy	Policy to be reviewed 2015 following audit Trust wide audit of clinical risk assessments to be undertaken 2015	Adult and Older Peoples Mental Health service Director/Head of Performance	May 2016
	b) CPA documentation forms part of case notes/electronic records and is not maintained separately	Criteria included Suicide Prevention Audit (SPA) collated and reviewed 6 monthly in SPSH Group with Local Leads.	3 monthly SPA Audit Documentation work stream on clinical information system PARIS New web link to an online form and new Report to be designed.	Patient Safety Lead/ Governance Managers Patient Safety Lead and Audit team	2016-2017
	c) All care plans will include explicit plans for responding to the needs of service users who find their care package unacceptable or who do not wish to engage with services.	SPA submits 3 monthly – SPA action plan discussed locally. DNA No access policy in place with specific standard operating procedures (CAMHS) Supervision procedures in place	Continual quality monitoring through the PSIG of Suicide investigation reports. Annual report produced and shared across the Trust on all suicides data and themes	Patient Safety Lead/Governance Leads Mental Health	2016-2017

	d) Service users that are assessed high risk of suicide and have complex characteristics are allocated to the Care Programme Approach	CPA Policy sets out criteria for allocation of CPA, Includes criteria for those not allocated to CPA and process's for service users in receipt of drug and alcohol services that may not be subject to CPA	Complex cases steering group to identify actions to improve access and pathways for service users with co morbidity	Integrated Governance for Mental Health	2016-2017
	e) Service users are given contact numbers to use in times of crisis that gives them information on how to access appropriate advice and support	Identified telephone numbers for service users gives immediate response from staff and does not allow the potential for messages to be left that may not be actioned by staff.	Audit of current service options for telephone crisis response. Guidelines produced re use of answer machines and texts to service users within services Answer machine audit/ survey completed 2015	Results of completed Answer machine audit/survey to be considered at SPSH Working Group.	2016-2017
2.Secure and Forensic Mental Health	a) Patients diagnosed with Schizophrenia with complex needs if convicted of an offence are normally treated in hospital rather than the prison service.	Prison Mental Health In-Reach Teams to coordinate assessment and arrange transport to hospital if deemed appropriate. All boroughs have processes in place with criminal justice workers and forensic services pathway. RHSD clinical pathways team to coordinate referrals into PCFTs low secure inpatient facilities and access to medium or high secure facilities that are provided outside the PCFT footprint for those service users requiring this facility.	Continual monitoring of provision and referrals	RHSD Directorate manager and clinical pathways team lead	2016-2017

	b) There is sufficient capacity in the provision of low and medium secure beds and PICU beds.	Review of access to low secure beds and flexibility of access out of hours.	Weekly referral pathway meeting for secure provision will be monitored through the reports following incidents. PSIG will review any incidents in relation to access to PICU beds.	RHSD Directorate manager and CAPACITY AND Flow Admin manager (for secure beds).	2016-2017
	d) Observation and Engagement Policy and current practice reflects current evidence about suicide risk found in risk assessments	Observation and Engagement Policy provides guidance to raise or lower the level of observation. Local Induction guidance includes observation and engagement procedures for agency bank and new staff Search Policy is included within training program. Ward process's being reviewed as part of Productive Mental Health Ward including process's for safe and supportive observations	All wards have a therapeutic programme established and activities have been risk assessed. A clinical risk assessment and a pre-activity risk assessment is completed prior to service user engagement in activities organised by the Trust.. Annual audit of observation and engagement policy	Acute Care Forum Patient Safety Lead L and D Department	2015-2017

	e) A protocol has been developed to allow and advise staff to remove from service users both in patients and community all items which could be used to self harm as well as potential ligatures from those assessed as being significant risk of suicide or who may present of harm to others. Includes medicines and substances	Protocol in place Search policy in place that has been reviewed by a service user	Removal of lighters (or items that can be used to ignite fire) procedure in place for inpatient units	Acute Care Forum Smoke Free Group DIGGs	**2016/2017**
	g) Environmental difficulties in observing patients are made explicit and remedial action is taken as far as possible to reduce risk to the patient	Environmental audits identify areas where difficulties exist for observing patients and local arrangements are in place for remedial action E.g. Move patients to a safer area Risk Management strategy describes systems in place for reporting Risk to the Trust board	Completion of Ligature Audits Garden Risk Assessments review (access to roof) Environmental Audits for 2015/16	Ward Managers/Estates department Governance Managers Health, Safety and Emergency Planning Manager; CMHT managers	**2016/2017**
3.Post Discharge prevention of Suicide	a) Prior to discharge inpatient/ Crisis teams, Home treatment teams and Community teams should carry out a joint case review if this is clinically indicated.	An up to date risk assessment has been completed with patient involvement prior to discharge and included within the patient's clinical case file. Both inpatient/ Home treatment teams and community staff have been involved in the review of the risk assessment.	CPA Policy and Discharge procedures include information required to be documented and communicated to all agencies/carers /relatives. Suicide Prevention Audit completed 6 monthly. Patient Safety Improvement group		2016-2017

		The discharge care plan identifies specific arrangements for promoting compliance and engagement with treatment CMHT/ Access & Crisis teams and Home treatment teams are in place for high risk clients who may disengage or the care plan specifies arrangements for assertive follow up and support Family carers and significant others have been involved and contributed in the discharge care planning process. Care plan documents how family and carers can help patients and this is promoted within STORM training. CAMHS – Whilst those who meet the criteria for adult MHS are followed up by the CMHT, crisis teams, home treatment teams on discharge, CAMHS IROR, Transitions Teams and Out patient CAMHS provide a high level of support post discharge.	reviews incident reports to ensure compliance with policies and procedures. Information leaflets developed re keeping safe for both service users and their relatives Information leaflets reviewed 2015 and to be made available across all services and placed on the Trust Intranet and via Pennine Post. Development of an integrated system with external agencies of follow up for service users following discharge from services. Joint partnership work with Samaritans established December 2014. 3 monthly review meetings in place to continue throughout 2016/2017. (CAMHS) Joint partnership work agreed with Papyrus Jan 2015. Support for ASSIST training funding agreed. Papyrus contact numbers added to Keeping Safe leaflets. Community	Audit department/ Adult and Older Peoples Mental Health Service DirectorPatient Safety Lead Acute Care Service Manager	

			development project agreed to be piloted in Tameside whereby young people will be trained in ASSIST and supported to carry out 3 suicide prevention activities by Papyrus.		
	b) Pennine Care Sign Up to Safety plan includes pledge to eliminate unsafe leave and discharge from all inpatient facilities within Pennine Care	Sign Up for Safety Plan includes work plan specific to unsafe leave and discharge	To be implemented by Acute Care Forum and Tier 4 Group.	Monitoring via Sign up for Safety Project Group- meeting dates arranged for 2015.	2016-2017
	d) Patients who have been assessed as being at high risk of suicide during the period of the admission are supported whilst on leave from the ward. This could include telephone contact. Any carer, family or friend who is offering care	Leave plans and discharge plans indicates whether compliance/engagement difficulties are anticipated and the actions to be taken as appropriate. Return to ward plans identified with carers and significant others	PSIG will review SUI's to identify lessons learned for information sharing within Integrated Governance Groups Contingency plans. No access and DNA Policy and procedures in place.	Patient Safety Lead/ Governance Managers Ward managers	2016-2017

	whilst on leave must be appraised of the current risk and understand the nature of the patient being on leave. For CAMHS cases up to 16 years old, 18 years if admitted to Hope/ Horizon Unit) services would be supported (in-reach/ outreach services.)				
	e) An agreed clinical team follows up patients who have been at risk of suicide during the period of admission within 7 days of discharge. 48 hours follow up for high risk service users.	All Breaches monitored through local governance arrangements monitored within LDPR. SPA Audit results. Progressed – telephone contact not acceptable. SUI Review panel with Governance Managers Patient Safety Improvement Group.	Monitoring arrangements in place to continue 6 monthly SPA data collated and exception reporting shared with DIGGs	Governance Managers Performance and Information team	2016-2017

4.Family and Carer Contact	a) The Trust has a policy/guidance on carers discussing their views and concerns with members of staff. If a patient does not give consent to contact family/ carers/significant others it is imperative that staff are aware that in certain circumstances they can legally ascertain this information through the MDT where there are concerns of severe harm to the patient and or others	Policies to include issues regarding consent and family carer involvement with reference made to capacity issues. Where consent was not given and the team still made contact justification must be documented within the clinical case notes. Carer's families are given an opportunity to contribute to the gathering of information in the assessment process. Families carers and significant others have been given a clear procedure for making contact with services at all times	The following policies have been reviewed to include issues regarding consent and family carer involvement and procedure for making contact with services and documentation of same. Safeguarding Adults Clinical Risk Assessment Information Governance Polices Pennine Care has signed up to the Triangle of Care to improve carer engagement in acute inpatient and home treatment services.	South Service Director/ Project Director SLM Training. PALS Patient Safety Lead Information Governance Manager	2016-2017
	b) Where consent has been given the family and carers are contacted within three working days of an admission and are given clear mechanisms for making contact with services/clinical team	Service user and carer's groups are facilitated within D&A Directorate. Stockport & Bury DAS run carer's support groups. Carers in Tameside can attend a group run by probation & supported by the DAS. Rochdale can refer to a carer's group run by ADS (Addiction Dependency Solutions). All services offer telephone support to carer's as required & individual support as appropriate. **CAMHs**	To consider system for monitoring within the Governance meetings ACF and Tier 4 working groups.		2016-2017

		Consent is obtained from legal guardian or parent's pre/during admission. All young people aged 13-16 are assessed for Gillick / Fraser competence, any issues regarding consent to share information with families and in certain circumstances the families/guardians would be contacted where there are concerns regarding safety to self or others.			
	c) All clinical staff receive training on carers rights and involvement in assessment care planning and discharge	Standard assessment tool within TARA and PAD All services have a DSH group/ DBT group/ individual therapeutic approaches/ pathways to follow. A&E triage tool developed and implemented in Stockport and Tameside. Tier 4 network prepared for 'making it better' where inpatient children beds were be closed in Bury and Rochdale, protocol in place regarding assessment/transfer of care back to locality.	This is included in the CPA training e-learning CAMHS IAPT is currently being rolled out across the directorate for provision of CBT & Parenting, SFP, IPT. Joint collaboration consultation offer to network around the child (YOT.) LAC Mental Health Teams available within / alongside Oldham, Rochdale, Bury and Stockport. Tameside LAC provision sits outside CAMHS and consults as required with CAMHS.	MVA Network Manager	2016-2017

			Transition teams/ up to 18 years provision for those who do not meet the threshold for AMHS across the borough in place.		
	Postvention for families bereaved by suicide	The Trust is a partner funder of the Postvention research at Manchester University and as such will send staff on the yearly conference to learn about postvention theory and practice	Pennine staff to attend the conference Patient Safety lead to develop actions based on the postvention research Patient safety lead to consider training needs of the workforce in delivering postvention work	Patient Safety Lead	2016-2017
5.Appropriate Medication	a) Patients who are considered to be at risk of medicine related self harm should have their medicines reviewed by the prescribing clinician and where necessary action taken to further minimise risk both as in-patients and as out-patients; liaison must also occur with GPs who take over prescribing responsibilities.	SPA includes criteria regarding discharge medications prescribed 12 monthly reviews are carried out on all service users prescribed medication. Strategies in place to minimise the opportunities for prescribed medication to be used as a means of self harm for those patients deemed to be at risk of self harm if taken in overdose. Care plans should identify the potential for medicines to be used as a means of self harm and where applicable carers understand this risk Patient safety plans should	A review of this usual Suicide Prevention Audit that is completed on all suspected suicides and a report produced 6 monthly, by the SP&SH group PSIG reviews all SUIs shared learning is taken through Divisional Governance Groups. Within D&A Directorate, daily dispense and supervised consumption of medication are utilised to reduce risks of intentional and accidental harm.	Patient Safety Lead	2016-2017

		include the removal of lethal amounts of medications in times of crisis and replaced with daily support from HTT.	Care coordinators		
	b) Patients who are prescribed psychotropic medication as a treatment choice and are considered to be at risk of medicine related self harm should be monitored and given appropriate information to enable them to make an informed choice and to enable carers to contribute towards the decision making	Care plans and discharge letters to General Practitioners include explicit advice on appropriate monitoring prescribing quantities and risks associated with any other medicines the patient is taking. Monitoring procedures re medication in place	Information leaflets regarding service user's medication are available to service users and their carers.	Chief Pharmacist / Patient Safety Lead	2016-2017

	DSH groups/ DBT pathways are in place across the boroughs. Early Intervention Teams in place. A and E triage tool implemented in Stockport and Tameside. Ongoing work with tier 4 network has occurred for making it better in Bury and Rochdale. Emergencies for self-harm and overdose are diverted by ambulance to other local hospitals with a paediatric facility.	CAMHS have forged a partnership with PAPYRUS and implemented several work streams across the boroughs. All patients presenting through urgent care pathways will be given the Hopeline UK telephone number. Training opportunities have been purchased from PAPYRUS to train the children's workforce on suicide prevention. Training pack is developed and should be delivered to A and E and paediatric staff (medical and nursing.) This should be delivered on a rolling programme to account for staff changes. Assessment documentation proforma completed to refer to CAMHS.	CAMHS IAPT continues to be rolled out across the directorate for provision of CBT and parenting. IPT and SFP. Advice and consultation to the children's workforce in new redesign across CAMHS (integrated support and liaison.) YOT workers/ liaison in CAMHS to support high risk groups. Transition teams in Oldham, Rochdale, Tameside, Stockport for those who do not meet the threshold for CAMHS.	Patient Safety Lead/ Medical Director. CAMHS Service Lead. CAMHS Team.	

	d) CAMHS tier 3 agencies effectively work in partnership with the voluntary and community sector to support and advice on the identification of self-harm issues and to ensure rapid responses where appropriate. Buckley Hall reference removed.	CAMHS tier 3 services provide advice and consultation to tier 2/1 services (voluntary and community services) to support and offer guidance in identifying suicide and self harm risks in young people.	'With U in Mind' resource available for young people, leaflets, website and cards. Ongoing responsibility for CAMHS under NSF 9'.	Borough representatives	
6.Co-Morbidity/ Dual Diagnosis	a) Strategy exists for the comprehensive care of people with co-morbidity/ dual diagnosis (i.e. people with mental health problems and drug and alcohol disorders).	Trust strategy exists for Dual Diagnosis that includes liaison between mental health and drug and alcohol services statutory and voluntary agencies training in co-morbidity/dual diagnosis and the appointment of key staff to lead clinical developments	Review of Trust Dual Diagnosis Strategy and pathways into mental health services for service users with a drug and alcohol problem 2014/15. Learning Disability Directorate developing Joint Protocols in each borough between LD and Mental Health services to focus on both community and inpatient services. Complex clients steering group commenced to review current pathways and training agree actions	Integrated Governance Lead Mental Health	2015/16

			for this client group		
	b) Staff who provide care to people at risk of suicide are given training in the clinical management of cases of co-morbidity/dual diagnosis approved by employing organisations	Training in co-morbidity is provided across the Trust The number of staff that have completed the required training will be monitored by the Educational Governance Group	Training to be reviewed and completion to be monitored. Bespoke STORM self-harm and suicide prevention delivered to D&A Directorate clinicians	Joint Head of Organisational Learning & Development	
7.Post Incident Review	a) The Trust has a policy guidance on all incident reviews	The Trust Incident Investigation and Management Policy is reviewed annually Weekly Patient Safety Improvement Group reviews all SUI's In SSD monthly governance meetings (RHSD/CAMHS/ Learning Disability/ D&A/) themes report' monthly for each of the directorates that is presented within the separate governance groups. Progress and shared Learning is agreed and shared with teams/wards via team meetings.	Review of process's and procedures for incident reporting took place 2014. On-going review of Risk Department 2016	Integrated Governance Lead for Mental Health. Patient Safety Lead	2016-2017
	b) Suicides and serious suicide attempts are reviewed in a multi agency forum within a reasonable time to include as far as possible all staff involved in the care of the patient; this	Incident Reviews are completed for all Suicides and serious suicide attempts and involve the key staff involved in the patient's care. All Investigation Reports are scrutinised by the PSIG. Table top reviews may be	Risk department to review existing arrangements Establishment of the Mortality Review Group	Integrated Governance Lead for Mental Health. Patient Safety Lead Patient Safety Lead & Medical Director	2016-2017

	will inform over-arching reports to be via the Mortality Review Group who will report to Board	commissioned or full independent RCA investigation. All inpatient suicides will be subject to an Independent Root Cause Analysis Investigation. The Mortality Review Group will over a line of sight on suicide trends to the Board			
	c) All staff patients and families/carers affected by a serious suicide attempt are given prompt and open information and the opportunity to receive appropriate and effective support as soon as they require it. The risk department has the NHS England publication *Help is at Hand* to share if required	Incident Policy describes process and support for involvement of families carers affected by any SUI. Support for staff will be made available through the service manager as per policy and monitored through the PSIG. Principles of Being Open (NPSA 2009) have been incorporated into the Trust Incident Policy and are monitored by the PSIG Help is at hand leaflet available Staff survey undertaken into new Statutory Duty of Candour guidelines undertaken 2015 to establish baseline of staff understanding around roles and responsibilities.	RCA training to be reviewed for 2015/16. Information leaflets for carers following their relative's suicide attempt to be available. Risk Management training to be delivered Results of Duty of Candour survey to inform training requirements for all staff.	Trust Investigation Coordinator/ Patient Safety Lead, Governance Managers Head of Organisation Learning and Development	2016-2017

	d) All staff patients and families/carers affected by a suicide or a serious suicide attempt are given an opportunity to contribute to the SUI review and the final report.	The Trust has adopted the Being Open Principles 2009 NPSA Guidance. All reports following investigations are shared with the families. Trust board receives a quarterly Governance Report on identified themes emerging from SUI's and Root Cause Analysis	Completion of RCA training to be reviewed 2015 The contribution of family carers and others involved in SUIs are considered as part of the monitoring in the PSIG. SUI investigations/ Risk Management Training	Patient Safety Lead /Trust Investigation Coordinator	2016-2017
8.Training of Staff	a) All care staff in contact with patients at risk of self harm or suicide receive training in the recognition assessment and management of risk at intervals of no more than three years	The Trust Training Needs Analysis has included training in Risk Assessment for staff to receive an up date every three years All skills based training will be linked to OLMS which will give evidence of compliance against required training. Training records are submitted to the Educational Governance Group 6 monthly and monthly to Service Line Managers STORM training and STORM facilitator training available. Learning Disability (LD)/MH Self Assessment Action Plan Action Plan Includes. Provision of Learning Disability Awareness Training to staff working on the acute mental health wards	(STORM) training has now become a mandatory requirement for all staff that have responsibilities for the completion of risk assessments. Risk assessment competencies of staff are monitored through supervision. CAMHS specialist trainer in place. STORM Training for managers Developed network of ward based MH/LD Champions accessing borough based placements with local LD Community Teams	Joint Head of Organisational Learning & Development / MVA Network Manager OLM	2015/16

	b) The training is comprehensive evidence based and up to date includes National Confidential Inquiry recommendations c) The training now includes an explicit formulation element to process and communicate risk of self-harm	Training includes: Indicators of risk High risk periods Managing non compliance. Managing loss of contact. Communication between services agencies professional users and carers Mental Health Act. Suicide Prevention Audits National Confidential Enquiry concerns and recommendations are communicated to the L and D Department. Learning Disability (LD)/MH Self Assessment Action Plan Action Plan Includes. Provision of Learning Disability Awareness Training to staff working on the acute mental health wards Developed network of ward based MH/LD Champions accessing borough based placements with local LD Community Teams	Risk department to continue liaison with Learning and Development Department. Themes from SUIs to be communicated to L and D department to inform training	Patient Safety Lead / MVA Network Manager	2016-2017

9.Promote mental health among people from black and ethnic minority groups, including Asian women	a) The workforce target for Community Development Workers (CDWs) for BME Communities has been achieved.	There are BME CDWs in Rochdale, Oldham and Bury, and the Trust has links with BME project workers in Stockport and Tameside. PALS & 2 FT Member Councillors. CDW meetings have examined the need to deliver awareness raising and preventative strategies in localised BME populations, with the aim of promoting an understanding of mental health and wellbeing, improving access to and experiences of mental health services.	The Trust will continue to work closely with BME CDWs and project workers across the Trust to promote mental and physical health and wellbeing. The Trust now includes community health service and work is ongoing to make the most of opportunities to promote health and wellbeing initiatives to BME communities. This work will be led by the Trust's Equality and Diversity Steering Group and CDW and BME Project Worker Group.	E&D Manager	2016-2017

	b) The workers are operating effectively within a locally agreed strategic framework.	Localities and directorates have established E&D work groups and related action plans (which include CDWs and other partners). The plans include specific actions in relation to ethnicity and mental health and across the range of equality ‘ These local plans inform the Trust’s overarching E and D Business Plan.		E&D Manager	2016-2017
10.CAMHS	a) There is a comprehensive CAMHS service which specifically includes a mental health promotion function	The local CAMHS strategy groups are working towards the comprehensive CAMHS agenda. LD expertise has been developed in CAMHS to ensure the MH needs of children and young people with LD are met. 16-18 young people’s mental health teams have been established. Hope Unit and Horizons unit available to under 18s. An active CAMHS service user participation programme has been in place for over a year.	Service user participation is integral to CAMHS, examples are Young People Design Group for the Woodland Retreat, Recruitment panel consisting of young people and their involvement in producing information aimed at young people. Ongoing participation of young people in the development of CAMHS.		2016-2017

11. Information Sharing	a) Respective organisations to exchange information on suicides and check against databases of known individuals using mental health services.	f Patient Safety Lead – Attendance at Greater Manchester Suicide Prevention Network to continue. Rochdale SP Group Information from GM SPN shared with Leads at SPSH.	Attendance at groups to continue 2015 To forge links across all boroughs to support the development of a local suicide prevention action plan within the Pennine Care footprint Intention to further develop a Greater Manchester suicide prevention network with best practice and research sharing as key principles.	Patient Safety Lead	2016-2017
12	The medical director has requested local representation in the Township Suicide prevention strategy groups; these PCFT staff will represent the Trust and be a conduit of local best practices and innovations	Information shared via the SP&SH group	Local information shared from the Public Health England group and information shared to the Public Health England groups	Local Borough Leads	2016-2017