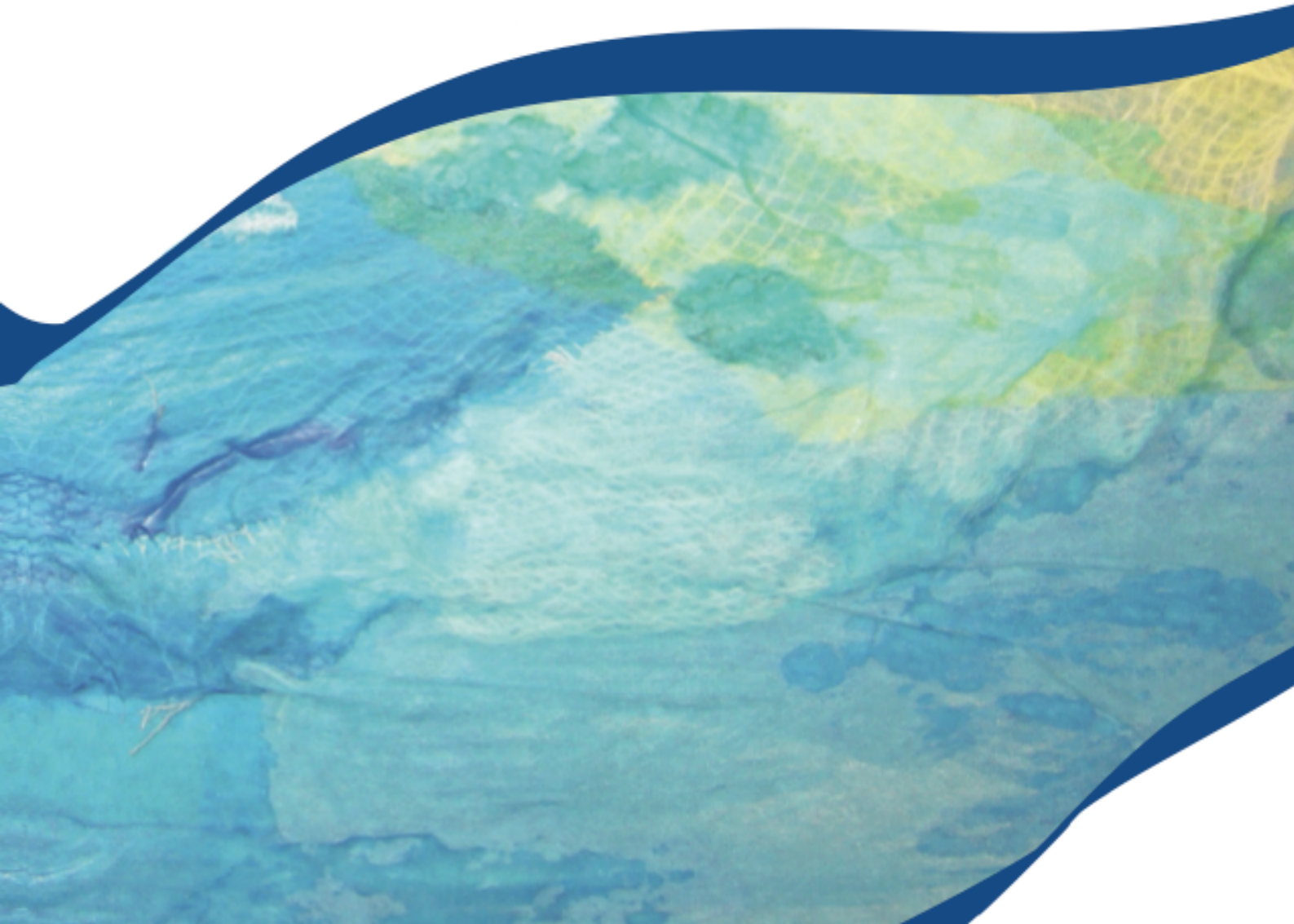


Changing Minds

Preventing Suicides in Walsall

An Audit of Mental Health Services

March 2008



Acknowledgements

We would like to thank the following members of the audit working group for their hard work and contributions in undertaking this audit.

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1. EXECUTIVE SUMMARY

Introduction

Suicide is an act of deliberate self-harm which results in death and is a devastating event with far reaching consequences for family, friends and those professionals involved in caring for the person. It is also a major public health issue. Nearly 6000 people commit suicide in England each year, only a quarter of which are in direct contact with specialist mental health services. The majority of people who commit suicide suffer from a mental disorder, commonly depression. Alcohol and substance misuse and personality difficulties are also common contributing factors. Men are three times more likely to commit suicide than women and suicide remains a leading cause of death in young men aged 19-34. Nationally, suicide rates in South Asian women aged under 35 have risen.

Walsall has always performed well in terms of suicide prevention targets. Throughout most of the 1990s the suicide rate in Walsall was well below the national average. However, more recently we appear to have lost this lead and for the first time in the period 2003-05 Walsall's suicide rate is higher than regional and national averages. Presently we are not on course to meet the 2010 target. It is timely then that we renew our focus on preventing suicides locally. This has been done in the context of developing a strategy for suicide prevention and the promotion of mental well being in Walsall.

The *National Suicide Prevention Strategy for England (2002)* sets out a comprehensive evidence-based strategy for preventing suicide. NIMHE (now CSIP) has produced a suicide prevention toolkit to support the strategy. Underpinned by the findings of *Safety First, a report from the National Confidential Inquiry into Suicide and homicide by people with mental illness*, the toolkit provides a simple way of measuring service standards across the care pathway.

This toolkit has been used to audit specialist mental health services in Walsall.

We have aligned our analysis and discussion with the key messages from *Avoidable Deaths (2007)*, the most recent report of the National Confidential Inquiry into suicide and homicide by people with mental illness.

Key findings and recommendations

We are not currently meeting most of the standards as set out in the toolkit.

Standard One: Appropriate level of care

Findings:

- CPA is not used universally across the service. 71% of cases had CPA.
- Where CPA is used often it is not at the most appropriate level. Less than 50% had enhanced CPA.
- Significant variation in format of case notes and inclusion of CPA documentation across the service.

Recommendations:

Attention needs to be focussed on the universal adoption of CPA at appropriate levels, utilising robust suicide risk assessment methods.

- Produce an action plan for universal implementation of CPA at appropriate levels across the service.
- Rolling programme of update training on use of CPA for all clinical staff.
- Review integrated note system – include CPA documentation as part of multi-disciplinary notes.
- Audit CPA use in 12 months.

Standard Two: Inpatient suicide prevention

Findings:

- Good implementation of environmental risk assessment.
- Under use of annual ligature point audits.
- Evidence of robust implementation of observation policy in 1 case.

Recommendations:

Focus on robust annual ligature audit and environmental risk assessment.

- Implement annual ligature audits on all wards.
- Review action re: door as ligature points.
- Maintain high standards of environmental risk assessment.
- Progress review of observation policy.

Standard Three: Post discharge prevention of suicide**Findings:**

- Low level of pre-discharge reviews is of concern (only 55% of patients had a review).
- Very few patients had evidence of suicide risk assessment (40%).
- Significant variation in follow-up times and methods following discharge from service. Only 10% had follow-up within 48 hrs of discharge.
- Approximately 50% of family and carers were involved/given information about their relative's needs or action to be taken if risk increased.
- 57% of patients with a dual diagnosis had documented plans for how their needs would be met.

Recommendations:

Address the heightened risk of suicide at discharge and points of transition by:

- Ensuring multi-disciplinary discharge review meetings take place and are documented.
- Undertaking suicide risk assessments on discharge from services, transition between services.
- Agree and implement a fail-safe discharge follow-up policy.
- Review procedure/application of procedure when patients abscond.
- Focus on identifying and meeting the needs of patients with dual diagnosis.

Standard Four: Family / carer contact**Findings:**

- Audit indicates more could be done to keep family/carers informed and involved.

Recommendations:

Make provision for involving family /carers by:

- Review procedures for ensuring family/carers are offered support/information regarding relatives where consent given.
- Identify a designated member of post-incident review team to liaise with family.

Standard Five: Appropriate medication**Findings:**

- Standard largely met; need to ensure prescribers are aware of prescribing best practice in patients at high risk.

Recommendations:

Update prescribers re best practise when prescribing for high risk patients.

Standard Six: Co-morbidity/dual diagnosis**Findings:**

- Standard not met – do not currently have a strategy for comprehensive care of people with a dual diagnosis.

Recommendations:

Improve care of people with dual diagnosis by:

- Developing a strategy for the comprehensive care of people with dual diagnosis, to include an examination of how data on co-morbidity/dual diagnosis can be used to inform decision-making.
- Review needs for training in dual diagnosis as part of training needs analysis and plan (see standard 8).

Standard Seven: Post-incident review**Findings:**

- Lack of robust, standardised approach for undertaking post-incident reviews.
- Impression is that service staff do not prioritise input into reviews, raising questions about their perceived value.
- Failure to incorporate the learning from the reviews systematically in the organisation.
- Little evidence that staff or family are adequately supported through this process.

Recommendations:

Develop a robust post-incident review mechanism which informs learning across the service

- Review the protocol/policy for undertaking post-incident reviews.
- Identify a senior clinician to work collaboratively with risk management team and provide senior clinical leadership.
- Develop a robust suicide surveillance system for Walsall.
- Produce a standardised form/record for documentation and progress chasing of reviews.
- Ensure that reviews are undertaken in a timely fashion.
- Strengthen the performance monitoring framework for completion of reviews.
- Review approach to information sharing with family/carers and the support offered to them.
- Identify/document process for supporting staff involved in reviews.
- Examine how learning from the review process informs staff and service development.

Standard Eight: Training

Findings:

- Organisation has implemented approved training in risk assessment and 60% of eligible staff have been trained.
- Recognised training courses in dual diagnosis.
- At present do not have robust training data management system.

Recommendations:

Comprehensive training programme to underpin service improvement

- Review/undertake training needs analysis.
- Roll out STORM training across primary care.

Performance monitoring

The action plan for this audit will be performance monitored by the mental health clinical governance task group, with quarterly exception reporting to the suicide review group.

Changing minds and culture

The audit has identified areas of good practise and it is recognised that local staff are committed and have worked hard to achieve this. It is also noted that there has been a significant amount of development across local mental health services in recent years. However, much remains to be done to achieve compliance across all the standards.

Avoidable Deaths has pinpointed culture and attitudes as a key area for action. It reports that clinicians believe that only a small proportion of suicides (19%) are preventable. To an extent this reflects the recognition that mental health patients overall are a high risk group. But, as *Avoidable Deaths* points out, there is a danger in going from recognising risk in patients as a whole to accepting the inevitability of individual deaths. Controversially to some, it suggests that all inpatient suicides should be perceived as preventable.

This audit is of value not only in terms of assessing current service provision but also as a barometer of cultural norms and attitudes within the service. What conclusions might we draw about service attitudes towards suicide and the extent to which it is preventable? At an organisational, team and individual practitioner level are we learning from the death by suicide of people in our care? This audit suggests a refocus on these issues is timely and warranted.

2. INTRODUCTION

Suicide is an act of deliberate self harm which results in death. It is a devastating event, with far reaching consequences for family, friends and those professionals involved in caring for the person. It is also a major public health issue. Nearly 6000 people commit suicide in England annually, of which only a quarter are in direct contact with secondary mental health services. The majority of people who commit suicide suffer from a mental disorder, often depression. Alcohol and substance misuse and personality disorders are also common contributing factors. Men are three times more likely to commit suicide than women. Suicide remains a leading cause of death in young men aged 19-34.

The *National Service Framework for Mental Health* (1999) standard seven outlines measures to prevent suicides, including delivery of standards one to six, which refer to promoting mental well being across communities as well as providing effective, accessible and quality mental health services. The *National Suicide Prevention Strategy for England* (2002) sets out a comprehensive evidence-based strategy for preventing suicide. NIMHE (now CSIP) has produced a suicide prevention toolkit to support the strategy. Underpinned by the findings of *Safety First, a report from the National Confidential Inquiry into Suicide and Homicide by people with mental illness*, the toolkit provides a simple way of measuring service standards across the care pathway. This toolkit has been used to audit specialist mental health services in Walsall.

The most recent report of the National Confidential Inquiry into suicide and homicide by people with mental illness "*Avoidable Deaths*" (2007) addresses the topical issue of safety and mental health; raising important questions. Where should the balance lie between patient protection and patient autonomy? How many deaths could services prevent? In our discussion we align the key messages from this report with our audit findings.

3. BACKGROUND

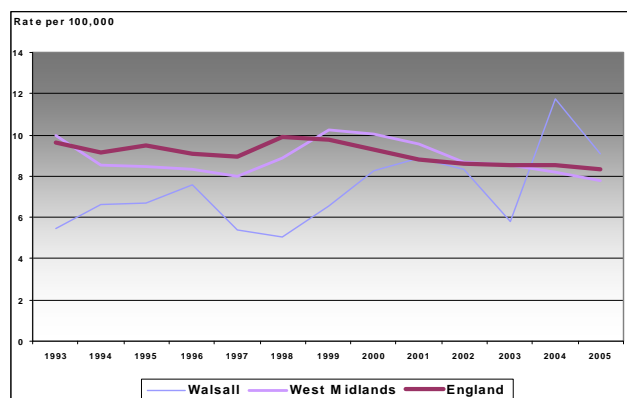
Walsall has always performed well in terms of the suicide prevention targets. Throughout most of the 1990s the suicide rate in Walsall was well below the national average (figure 1). In the baseline monitoring period 1995-97 Walsall's rate was below the national target rate for 2010. The Walsall target was therefore set to achieve a further 20% reduction (table 1).

Table 1: Walsall Targets

| By Year | % Reduction | Rate per 100,000 | Annual Lives Saved |
|---------|-------------|------------------|--------------------|
| 2005 | -12.0 | 5.7 | 2 |
| 2010 | -20 | 5.2 | 3 |

Source; Our Healthier Nation, progress report 2007

Figure 1: Age Standardised Mortality Rates for Suicide and Undetermined Injury, persons all ages, 1993 - 2005



Source: Compendium of Clinical and Health Indicators, 2006

Suicide data is difficult to interpret because of the small numbers and substantial year to year fluctuations. However, it would appear that in more recent times Walsall has experienced a trend for increasing suicide rates. In 2003-05 the Walsall rate was 35% higher than in 1995-97 (table 2). A consistent reduction to no more than 13 deaths per year is needed to achieve the 2010 target. This compares with an average 22 deaths by suicide per year in 2003-05. In the monitoring period 2003-05 Walsall's death rate has exceeded the regional and national average for the first time.

Table 2: Age Standardised Mortality Rate per 100, 000 Population, All Ages

| Region | 1995-97 (Baseline) | 2003-05 | Cumulative Progress | |
|----------------|-----------------------|---------|---------------------|--------------------|
| | | | % Reduction | Annual Lives Saved |
| PERSONS | | | | |
| Walsall | 6.55 | 8.87 | +35.4 | +5* |
| West Midlands | 8.26 | 8.17 | -1.1 | |
| England | 9.16 | 8.48 | -7.4 | |
| MALES | | | | |
| Walsall | 8.66 | 11.87 | +37.1 | +4* |
| West Midlands | 12.76 | 12.38 | -3.0 | |
| England | 14.10 | 12.86 | -8.7 | |
| FEMALES | | | | |
| Walsall | 4.60 | 6.05 | +31.5 | +1* |
| West Midlands | 3.90 | 4.1 | +5.0 | |
| England | 4.47 | 4.28 | -4.2 | |

Source: Our Healthier Nation Progress Report, 2007

*increase in deaths

Note: Male + Female 'lives saved' may not add to Persons 'lives saved' due to rounding

3. METHODOLOGY

After consultation with clinicians and service managers it was agreed that the toolkit would be used to audit local services.

4.1 Process

An audit working group was established with members from mental health services (including a specialist nurse therapist, two psychiatrists and a modern matron) public health, training department, pharmacy services and clinical audit. This group met regularly to inform the progress of the audit. The clinical audit team devised a data collection and analysis tool. Auditors included six trainee psychiatrists, a nurse and a pharmacist.

4.2 Study Sample

The audit group agreed an audit time period of June 2003 - June 2005. This time period had to be extended when auditing case notes for standard 7 (post-incident reviews) because there were insufficient cases for review in the original time period. The system for post-incident reviews had been revised considerably in 2005-06 and the audit group felt that it was important that the audit captured these changes.

A list of people who had died by suicide was compiled from the registrations of death reported to the PCT. It should be noted that this system captures all deaths registered in Walsall. It does not include death by suicide of Walsall residents if their deaths are registered elsewhere. This list was cross-referenced with mental health service records to identify those patients who were known to specialist services. This resulted in the identification of 14 patients.

Each of the community mental health teams, including the older people's teams and learning disability were asked to identify 3-4 patients who they currently considered "high risk" patients. A random selection of patients was chosen covering each sector. This resulted in 12 patients for inclusion.

The original study sample of 26 (14 completed suicides and 12 high risk patients) was reduced to 24, as notes for one high risk and one patient who had died by suicide could not be obtained in the audit time period. The final study sample comprised 13 patients who had died by suicide and 11 high risk patients (table 3).

Table 3: Sample Used in Suicide Audit, 2007

| Males (13) | | Females (11) | |
|------------|-----------|--------------|-----------|
| Suicide | High Risk | Suicide | High risk |
| 8 | 5 | 5 | 6 |

4.3 Study Sample Demographics

4.3 (i) Females

- The age range of women who committed suicide was 33 to 59.
- 3 of the 5 women who died by suicide were in their 30s.
- The women in the high risk category were aged 22 to 81.

4.3 (ii) Males

- The age range of men who committed suicide was 34 to 72.
- 4 of the 9 men who died by suicide were in their 40s.
- The men in the high risk category were aged 22 to 74.

4.3 (iii) Ethnicity

Patient ethnicity was not routinely recorded during 2003-2005. Crude analysis of surname suggests that 2 of the total sample were from an ethnic minority (1 high risk and 1 death by suicide).

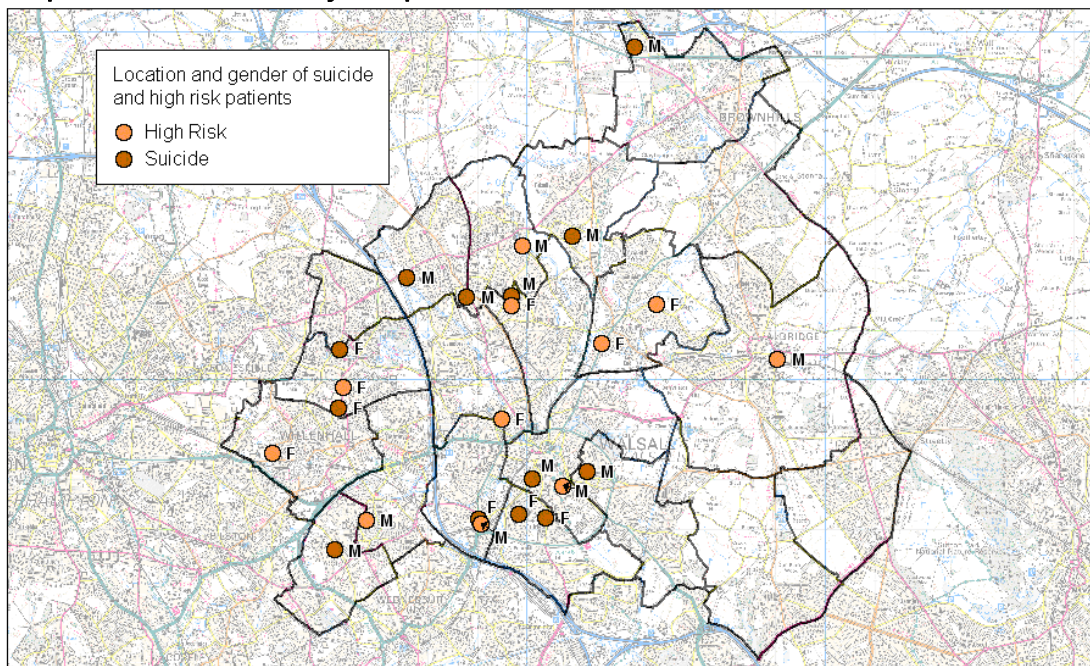
4.3 (iv) Occupation

Information about the occupation of those included in the audit is scant. Recording of occupation when deaths are registered is not always complete. Of those who died by suicide in our sample 3 (24%) did not have their occupation recorded, 5 (38%) were recorded as being unemployed and 5 (38%) had been in low-skilled manual occupations.

4.3 (v) Method of Suicide

Nearly half of those who died by suicide died in their own homes. 8 people died after hanging (suspension from a ligature), which was the most common cause of death. 3 of the suicides resulted from a drug overdose. 1 patient died from drowning and 1 had an "unascertainable" cause of death.

Map 1: Location of study sample -Walsall



5 FINDINGS

5.1 Standard One: Appropriate Level of Care

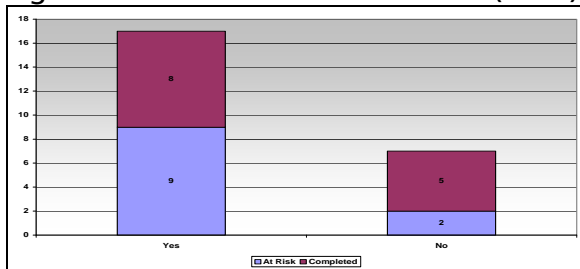
1. Patients "At Risk" are allocated to the enhanced level of the Care Programme Approach (CPA).
2. CPA documentation forms part of case notes and is not maintained separately.
3. These standards are monitored through clinical governance.

5.1 (i) Data Collection Questions

1. Is there a CPA Document?
2. Level of CPA assigned.
3. Is the CPA/Care Plan documentation part of the multi-disciplinary case notes i.e. it is not maintained separately (hospital or community notes)?

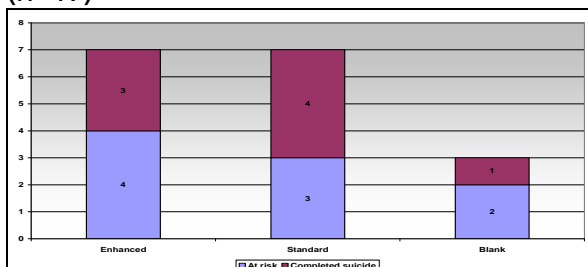
5.1 (ii) Results

Figure 2: Is there a CPA document? (n=24)



- (17) 71 % of notes had CPA documentation.
- Of 13 completed suicide (8) 61% had CPA documentation, (5) 39% did not.
- Of 11 high risk patients (9) 81% had CPA documentation, (2) 19% did not.

Figure 3: What Level of CPA was used? (n=17)

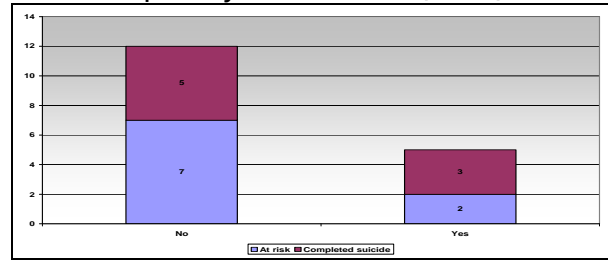


Of the 17 cases with CPA documentation:

- (3/8) 38% of patients who died by suicide had enhanced CPA, (4/8) 50% had standard CPA.

- (4/9) 44% of high risk patients had enhanced CPA and (3/9) 33% had standard CPA.

Figure 4: Is the CPA/Care Plan Part of the Multidisciplinary Case Notes? (n=17)



- (3/8) 38% of patients who died by suicide had their CPA as part of their multi-disciplinary notes.
- (2/9) 22% of high risk patients had their CPA as part of their multi-disciplinary notes.

5.1 (iii) Comment

The Care Programme Approach (CPA) was introduced in the 1990s as a framework for the holistic assessment of patient's health and social care needs. It is used to assess and manage clinical risk, plan care and review patients. It is an essential process for engaging with patients and improving quality of patient care and clinical outcomes. *Avoidable Deaths (2007)*, the latest report from the national confidential inquiry into suicide and homicide by people with mental illness highlights the importance of CPA. It reports that CPA continues to be under utilised in high risk groups, notably those patients with a combination of severe mental illness and previous self-harm or previous admission under the Mental Health Act. It argues that these patients make up 39% of the most preventable suicides.

5.1 (iv) Are we using CPA enough?

Whilst it is encouraging that 61% of those who died by suicide and 81% of the high risk patients reviewed had CPA documentation, the audit does demonstrate that the application and use of CPA is not universal across the whole mental health service. Suicide risk assessment is an important component of the CPA process. Limited consistency in applying CPA is likely to reflect under use of risk assessment also.

5.1 (v) Are we using the right level of CPA for patients?

It is generally agreed that enhanced CPA should be used for those patients considered to be at "high risk". Less than 50% of patients considered high risk and less than 40% of patients who died by suicide were subject to enhanced CPA. The limited use of enhanced CPA was also reported in *Avoidable Deaths*, where 35% of the sample had been under enhanced CPA. A fall from 47% since the last inquiry report.

These findings indicate that there are inconsistencies in the way CPA levels are agreed among various clinical teams and care co-ordinators. It is difficult in retrospect to comment on the findings for the suicide group, given the changing nature of suicide risk. However, it would be expected that all the high risk patients would be subject to enhanced CPA. The audit findings demonstrate that the application of enhanced CPA is not universal and consistent, representing a gap in service provision.

5.1 (vi) Is our documentation and note keeping robust enough?

Auditors commented on the fragmented nature of the notes audited and it is of concern that less than 50% of those who died by suicide and less than 20% of those patients considered at high risk had CPA documentation as part of their multi-disciplinary notes. This raises importance issues regarding documentation, note keeping and ultimately the ease of communication between staff about patient care and progress. The current format of single multi-disciplinary case notes for the inpatient setting was agreed some years ago as a transitional arrangement. Walsall tPCT was supposed to adopt electronic patient records (EPRs). Unfortunately, with the shelving of the plans towards EPRs, there is a need to look at the format of case notes afresh.

Recommendations

Attention needs to be focussed on the universal adoption of CPA at appropriate levels, utilising robust suicide risk assessment methods

- Produce an action plan for universal implementation of CPA at appropriate levels across the service.
- Rolling programme of update training on use of CPA for all clinical staff.
- Review integrated note system—include CPA documentation as part of multi-disciplinary notes.
- Audit CPA use in 12 months.

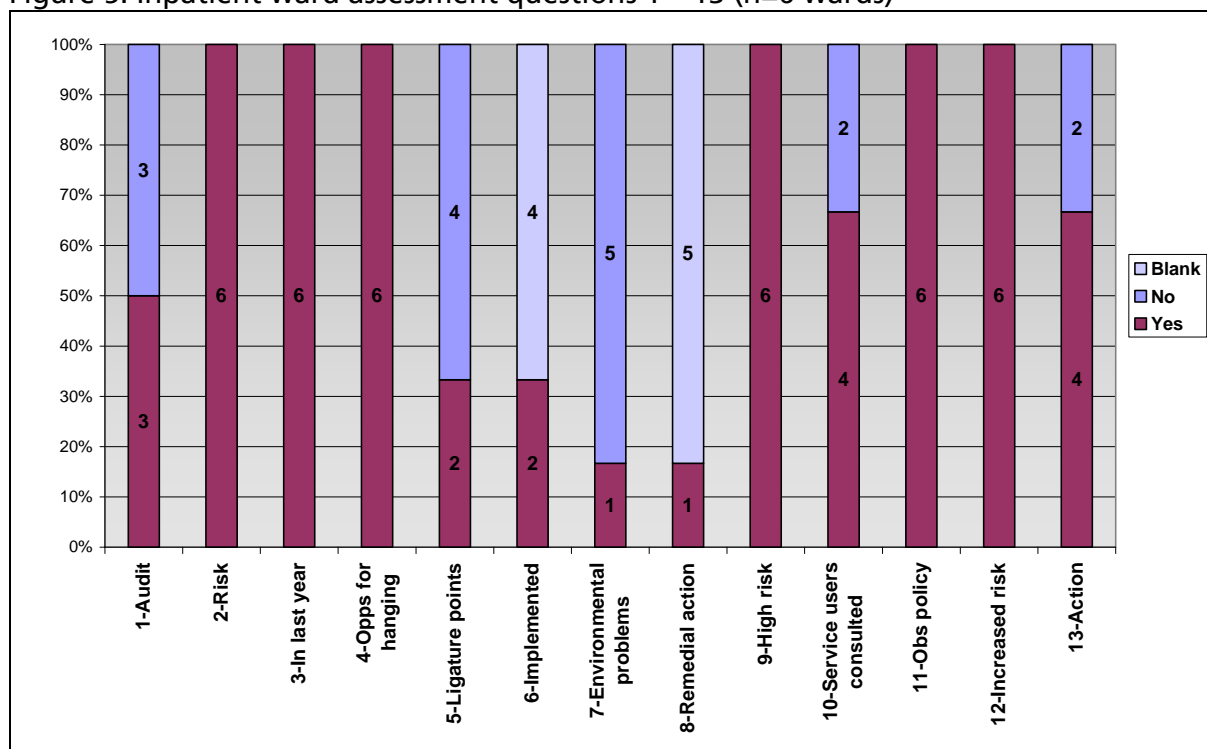
5.2 – Standard Two: Inpatients Suicide Prevention

1. Wards are audited at least annually to identify and minimise opportunities for hanging or other means by which patients could harm themselves.
2. Likely ligature points on inpatient units have been removed or covered.
3. A protocol has been developed to allow potential ligatures to be removed from patients at high risk of suicide.
4. Environmental difficulties in observing patients are made explicit and remedial action is taken as far as possible.
5. Observation policy and practice reflects current evidence about suicide risk.
6. Patients under any form of increased observation are not allowed leave or time off the ward.

5.2 (i) Data Collection Questions

1. Are wards audited annually to identify and minimise opportunities for hanging or other means by which patients could harm themselves?
2. Is there an environmental risk assessment for each ward?
3. Has it been completed in the last year?
4. Does it identify opportunities for hanging?
5. Does it include arrangements for removal of ligature points?
6. If yes to the above question – have the arrangements been implemented?
7. Does it identify environmental problems for observation?
8. If yes to the question above – are arrangements in place for remedial action?
9. Is there a protocol for removal of potential ligatures from high risk patients?
10. Were service users consulted in developing the protocol?
11. Is there an observation policy?

Figure 5: Inpatient ward assessment questions 1 – 13 (n=6 wards)



12. Does it make reference to periods of increased risk (evenings, night, gaps in continuous observation, apparent improvement in patient’s mood)?
13. Does it specify action to take at times of increased risk?
14. Does the care plan/CPA or patient record refer to increased observation in periods of increased risk?
15. Does the care plan/CPA or patient record any periods of unattended leave or time off the ward while the patient is under increased observation (more than general observation)?

5.2 (ii) Results

Inpatient wards at Dorothy Pattison Hospital (Ambleside, Langdale, Windermere, Grasmere) and 2 inpatient wards at Bloxwich hospital (Lindon, Cedars) were audited under this standard.

Question 14 and 15 applied to only 1 patient in the study sample.

5.2 (iii) Comment

In auditing this standard the distinction between Questions 1 and 2 should be noted. Q1 has been interpreted as referring to an annual ligature audit, whilst Q2 refers

to environmental risk assessments, which may include assessment of ligature points but in a more general fashion.

The audit demonstrated an excellent standard of environmental risk assessment with all wards having completed one in the last year. In contrast there was a difference in the use of annual ligature audits between the two hospitals. Bloxwich Hospital had completed a ligature audit on both wards in the last year and implemented arrangements for removal of ligature points. Whilst in Dorothy Pattison hospital only one ward has undertaken an audit of ligature points in the audit time period and reported that actions for the removal of identified ligature points had not been implemented.

It is of concern that despite comprehensive environmental risk assessments and the identification of opportunities for hanging, the audit reported that no arrangements have been put in place to address these issues in Dorothy Pattison Hospital. Clarification on this point was sort from senior clinical staff. They reported that whilst ligature points such as doors have been identified as potential areas of risk within the trust, addressing these issues is

challenging owing to competing demands on resources and the need to address equally important health and safety issues.

It is acknowledged that a significant amount of work has been undertaken around ligature points in the trust over the last few years. Whilst the ward environmental risk assessments will highlight ligature points it is recognised as being a generic risk assessment. An assessment dedicated to potential ligature points which is conducted on an annual basis and addresses all environmental factors including furniture and equipment may be a more affective way of reviewing ligature points.

Whilst continuous efforts are made to find solutions to reduce the opportunity for hanging an annual ligature review may also provide the opportunity to reassess best practise and review options with estates to address this issue.

The audit included 1 high risk patient who was subject to observation as an inpatient. In this case the observation policy was implemented rigorously. The observation policy reflects four levels of observation ranging from general observation to 1:1 observation within arms length and is in line with best practise nationally. A review of the observation policy is currently being undertaken for both adult acute services and older people's services.

However, it should be noted that this audit included only 1 case. Post incident reviews of people known to service who have died by suicide have identified significant shortcomings in the implementation of the observation policy on some wards.

Recommendations

Focus on robust ligature audit and environmental risk assessment

- Implement annual ligature audits on all wards.
- Review action re: door as ligature points.
- Maintain high standards of environmental risk assessment.
- Progress review of observation policy

5.3 - Standard Three: Post Discharge Prevention of Suicide

1. Prior to discharge inpatient and community teams carry out a joint case review.
2. Discharge care plans specify arrangements for promoting compliance / engagement with treatment.
3. Care plans take into account the heightened risk of suicide in the first three months after discharge and make specific reference to the first week.
4. Patients who have been at high risk of suicide during the period of admission are followed up within 48 hours of discharge by an agreed member of the clinical team.
5. Assertive outreach teams have been established to prevent loss of contact with vulnerable and high-risk patients.

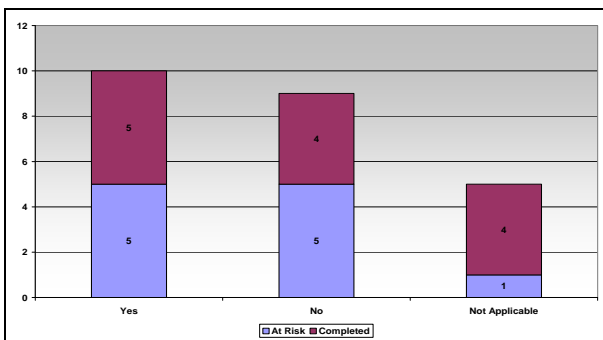
5.3 (i) Data Collection Questions

1. Was a multi-disciplinary CPA/Care Plan review recorded in the notes prior to the last discharge from in patient services?
2. Was a multi-disciplinary CPA/Care Plan review recorded in the notes prior to the last discharge from community services?
3. If a multi-disciplinary CPA/Care Plan review (inpatient or community CPA) is recorded, was it attended by community care co-ordinator and medical team / inpatient medical or nursing teams?
4. If a multi-disciplinary CPA/Care Plan review (inpatient or community CPA) is recorded was a risk assessment undertaken?
5. Does the most recent hospital, community or MH service discharge care plan/CPA or patient record specify arrangements for promoting adherence/engagement with treatment and care plan?
6. Does the care plan/CPA or patient record include actions related to heightened risk/signs of relapse in the first three months (3-6 months in community) after this discharge?
7. Does the record show that arrangements were made to follow-up the patient within 48 hours of this discharge?

8. Does the CPA/Care Plan or patient record for patients with dual diagnosis (mental disorder and substance misuse) identify how these needs will be met?
9. Does the care plan/CPA or patient record that family/carers have received information on how to help patients engage with treatment plans during relapse and crisis?

5.3 (ii) Results

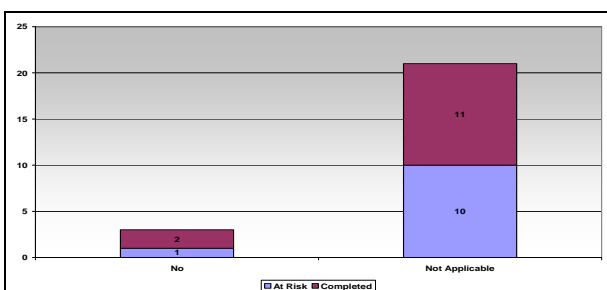
Figure 6: Was a Multi-disciplinary CPA/Care Plan Review Recorded in the Notes Prior to the Last Discharge from In-patient Services (n=24)



*Not applicable: 1 patient died when an inpatient and 4 patients had never been an inpatient

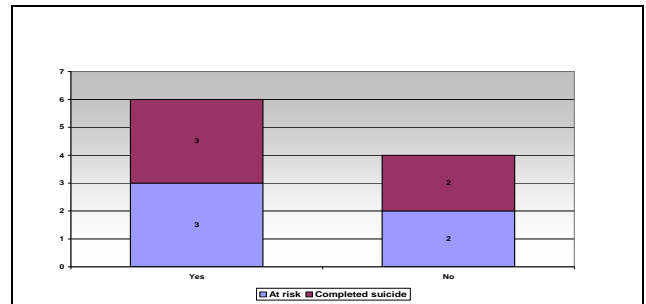
- (5/9 applicable) 55% of completed suicides had a review prior to discharge from inpatient services.
- (5/10 applicable) 50% of patients considered high risk had a review prior to discharge from inpatient services.

Figure 7: Was a Multi-disciplinary CPA/Care Plan Review Recorded in the Notes Prior to the Last Discharge From Community Services? (n=24)



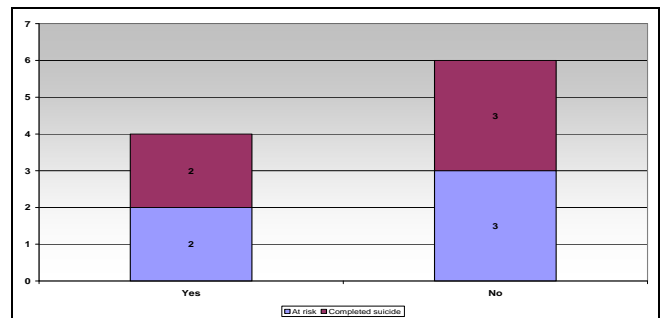
- None of the 3 cases where a review on discharge from community services was applicable actually had a review.

Figure 8: If a Multi-disciplinary CPA/Care Plan Review is recorded (In-Patient or Community) was it Attended by Community Care Coordinator and Medical Team/In-Patient medical or Nursing Teams (n=10)



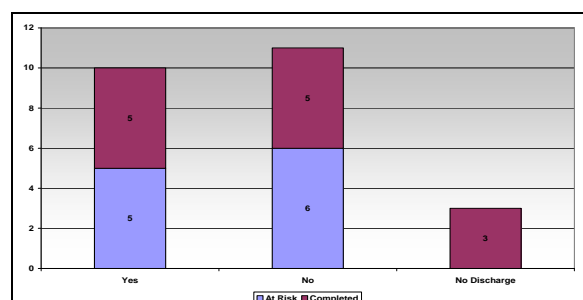
- 60% (6) of the reviews held were attended by a multi-disciplinary team with no differences between high risk patients and those who died by suicide.

Figure 9: If a Multi-disciplinary CPA/Care Plan Review (In-Patient or Community) is Recorded Was a Risk Assessment Undertaken (n=10)



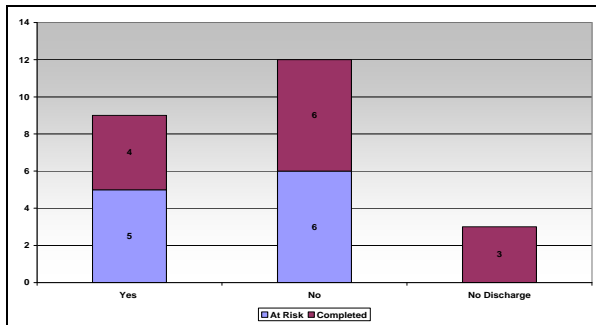
- (4) 40% of patients reviewed had a risk assessment documented with equal number for high risk and completed suicide patients.

Figure 10: Does the Most Recent Hospital, Community or MH Service Discharge CPA/Care Plan or Patient Record Specify Arrangements for Promoting Adherence/Engagement With Treatment and Care Plan? (n=24)



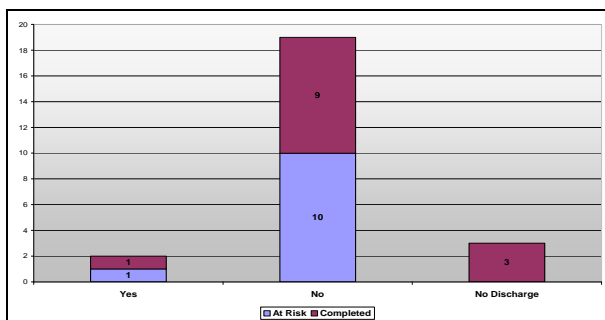
- (5/10) 50% of those who died by suicide had specific arrangements for promoting adherence to their treatment plan.
- (5/11) 45% of high risk patients have specific arrangements for promoting adherence to their treatment plan.

Figure 11: Does the CPA/Care plan or Patient Record Include Actions Relating to Heightened Risk/Signs of Relapse in the First Three Months (3-6 months in community) after this Discharge? (n=24)



- (4/10) 40% of those who died by suicide had actions relating to heightened risk/relapse in the initial months after discharge.
- (5/11) 45% of patients considered at high risk had actions relating to heightened risk/relapse in the initial months after discharge.

Figure 12: Does the record show that arrangements were made to follow-up the patient within 48 hours of this discharge? (n=24)

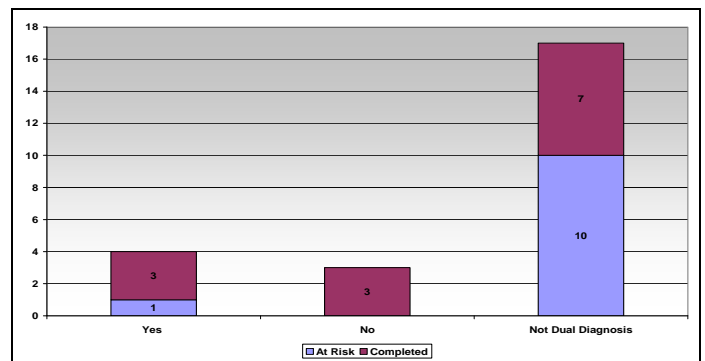


- (1/10) 10% of those who died by suicide had plans for follow-up within 48 hours.
- (1/11) 9% of those at high risk had plans for follow up within 48 hours.

Comments raised as a result of the above question are outlined below:

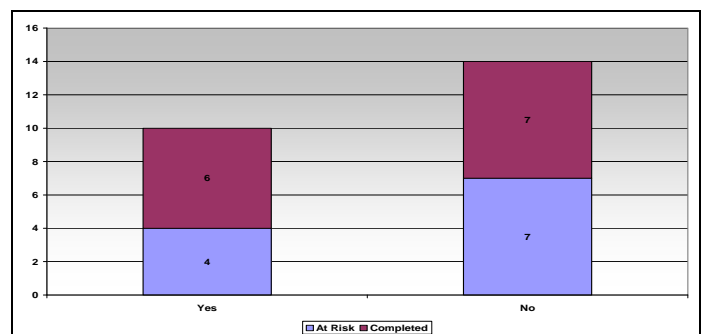
- Telephone call attempted. Visit done within 72hrs.
- Patient discharged from hospital to Broadway North supported accommodation.
- Patient absconded 2 days after the admission.
- The arrangement was to see the patient in the out-patient clinic in 4 weeks.
- Patient discharged against medical advice and not seen by services since (failed to attend out-patient appointment).
- Planned follow up within 6wks.
- No plan mentioned.

Figure 13: Does the CPA/Care Plan or Patient Record for Patients with Dual Diagnosis Identify How These Needs Will be Met? (n=24)



- (4/7) 57% of patients with a dual diagnosis had records showing how their particular needs would be met.

Figure 14: Does the CPA/Care Plan or Patient Record show that Family/Carers Have Received Information on How to Help Patients Engage with Treatment Plans during Relapse and Crisis? (n=24)



- The family/carers of (6/13) 46% of patients who died by suicide and (4/11)

36% of high risk patients had been given information on how to help patients during a relapse/crisis.

5.3 (iii) Comment

Avoidable deaths (2007) found that the period of maximum suicide risk is the transition from ward to community and calls for greater assessment and planning at these vulnerable points. The inquiry found that 15% of suicides occurred within the first week after discharge from in-patient services, with 22% occurring before the follow-up appointment in the community.

5.3 (iv) Are we reviewing patients appropriately before discharge?

This audit reveals a surprisingly low level of pre-discharge reviews, with only half of patients discharged from in-patients having a review. It is of concern that none of the 3 patients eligible for review on discharge from community services actually had one.

This finding was discussed with clinicians from the service who argued that this finding is likely to be due to poor documentation of reviews and the fragmented nature of medical records. All felt that reviews were taking place in practice. In addition it was pointed out that prior to 2004 only 1 out of 7 adult mental health teams actually had a substantive consultant in post with widespread use of locum staff, which may account for the inconsistencies in record keeping.

This finding does highlight the important principle of organising multi-disciplinary pre-discharge reviews and documenting them in a consistent manner.

5.3 (v) Are discharge reviews attended by relevant staff?

An encouraging number of discharge reviews (60%) were attended by a multi-disciplinary team. This refers to inpatient review as none of the three discharged from community services had a review documented in their notes.

5.3 (vi) Do discharge reviews include suicide risk assessment?

40% of patients had a suicide risk assessment documented in their notes, with equal proportions of high risk patients and

patients who died by suicide. This is a surprisingly low assessment rate.

5.3(vii) Do discharge plans indicate action to be taken in cases of relapse?

Approximately half of those eligible had specific arrangements for promoting adherence to treatment plans, but slightly fewer had plans for action to be taken in the case of a relapse or increased risk.

5.3 (viii) Are we following patients up quickly enough?

Only 10% of the audit sample were followed up within 48 hours of discharge. The data collection tool allowed for explanatory comments re follow-up. These demonstrate a diverse range of approaches to follow-up and considerable variation in follow-up times.

5.3 (ix) Are we meeting the needs of patient's with dual diagnosis?

7 patients in the audit had a documented dual diagnosis. Nearly 60% of these patients had a record of how their needs would be met in their records.

Discharge and transition between services are crucial times of increased suicide risk. *Avoidable Deaths* calls for several measures to improve safety at this point:

- Regular assessment of risk during the period of discharge planning and trial leave.
- Agreed plans to address stressors that may be encountered on leave and on discharge.
- Clear points of contact for patients and timely access to services if a crisis should occur during leave or after discharge.
- Early follow-up on discharge, including telephone calls immediately after discharge for high risk patients and face-to-face contact within a week of discharge for anyone receiving "enhanced" care under the Care Programme Approach (CPA).
- Support arrangements for people who discharge themselves from wards.

In mental health services often a fine balance has to be drawn between patient autonomy and patient safety. It is accepted that reviews may not be possible where a

patient absconds or self-discharges. However it is likely that the numbers falling into this bracket are low. *Avoidable deaths (2007)* found that 27% of the deaths by suicide were in patients who left the ward without permission, making them one of the highest risk sub-groups.

Recommendations

Address the heightened risk of suicide at discharge and points of transition by:

- Increasing the use of multi-disciplinary discharge review meetings.
- Undertaking suicide risk assessments on discharge from services, transition between services.
- Agree and implement a fail-safe discharge follow-up policy.
- Review procedure/application of procedure when patients abscond.
- Focus on identifying and meeting the needs of patients with dual diagnosis.

5.4 – Standard Four: Family/Carer Contact

1. Families/carers, with patient consent, are given a clear mechanism for making contact with an informed member of the clinical team at all times.
2. Families/carers are given appropriate information promptly following a suicide or homicide.

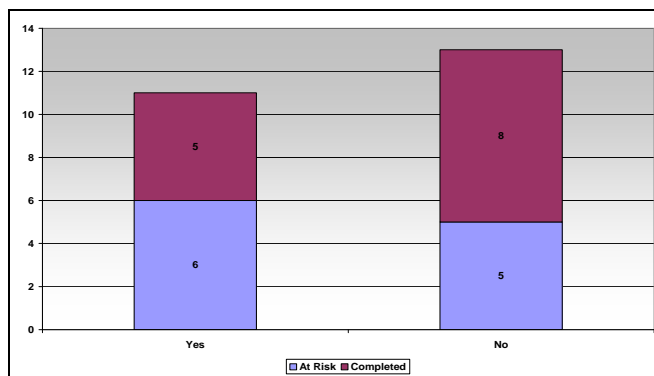
5.4 (i) Data Collection Questions

1. Does the care plan/CPA or patient notes record that family/carers have been given a clear procedure for making contact with an appropriate member of staff[#] at all times?
2. Does the record/CPA show whether patient gave consent for staff/MH professional to make contact with family/carers?
3. In cases of completed suicide is there written evidence in the clinical records that a member of staff was made responsible for ensuring that the family/carers were promptly informed of actions being taken?

5.4 (ii) Results

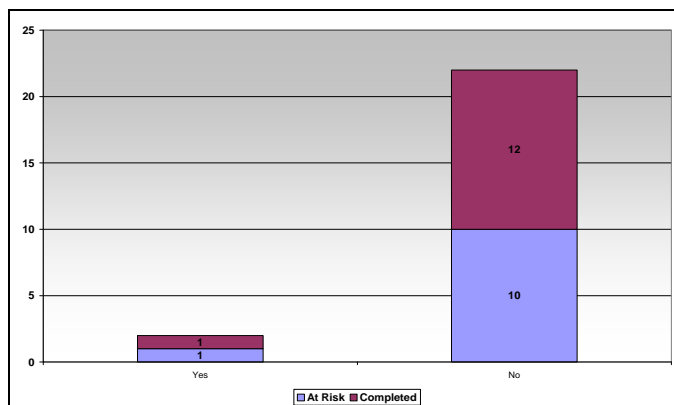
Figure 15: Does the CPA/Care Plan or Patient Record Show That Family and Carers Have Been Given Clear Procedure for

Making Contact With an Appropriate Member of Staff at all Times (n=24).



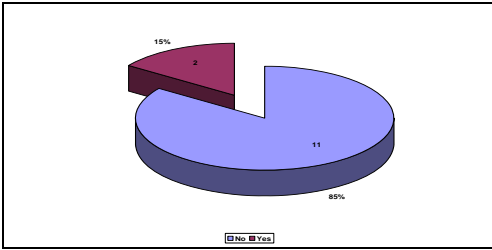
- (5/13) 38% of those who died by suicide had been given information on how to contact staff.
- (6/11) 55% of those at high risk had been given information on how to contact staff.

Figure 16: Does the CPA/Record Show Whether Patient Gave Consent for Staff/MH Professional to Make Contact with Family/Carers (n=24)



- (1/13) 8% of those who died by suicide had given consent for contact with family/carers.
- (1/11) 9% of high risk patients had given consent for contact with family/carers.

Figure 17: In Completed Suicides is There Written Evidence That a Member of Staff was made Responsible for ensuring that the Family/Carers were Promptly Informed of Action Being Taken (n=13)



5.4 (iii) Comments

Of all patient groups mental health service users probably see most of their specialist clinicians. Even so the time spent with clinician's accounts for only a tiny proportion of the patient's life. The role of family, friend and carers is critical for all patients with a long-term condition and one might argue even more so for patients with mental health issues. Keeping family and carers informed with the users consent and empowering carers and family is an important part of ensuring care for patients. The audit indicates that more could be done to communicate with and involve carers and family.

Recommendations

- Review procedures for ensuring family/carers are offered support/information regarding relatives where consent given.
- Identify a designated member of post-incident review team to liaise with families.

5.5 Standard Five: Appropriate Medication

1. Patients at risk of suicide receive the right medication in the right amounts.

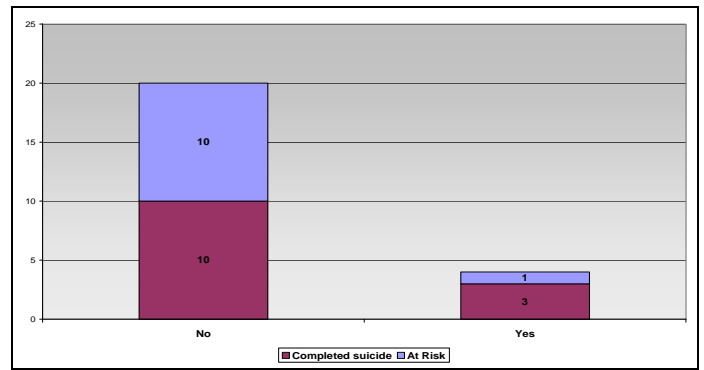
5.5 (i) Data Collection Questions

1. Were atypical anti-psychotics prescribed if non-compliant with standard anti-psychotics?
2. Has the patient had a history of self-harm in the last 3 months?
3. If yes, were they prescribed a supply of potentially toxic medication covering no more than 14 days?
4. Was it documented in the CPA/Care plan?

5.5 (ii) Results

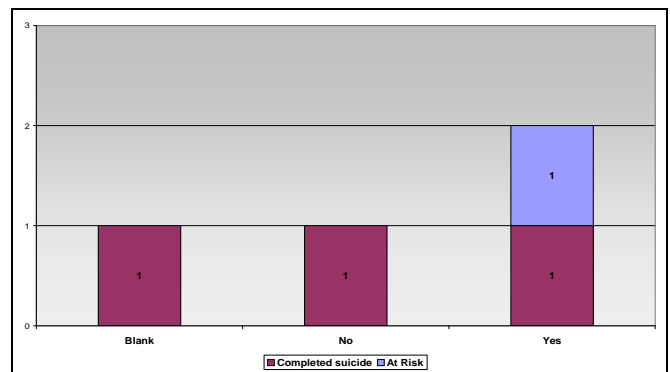
In the cases reviewed there were no known cases of non-compliance with medication.

Figure 18: History of Self Harm in the last 3 months? (n=24)



- (3/13) 23% of those who died by suicide had a history of self-harm in the last 3 months
- (1/11) 9% of high risk patients had a history of self-harm in the last 3 months

Figure 19: If yes, were they supplied potentially toxic meds covering no more than 14 days? (n=4)



- 2 patients with a history of self-harm were given medication covering more than 14 days, in neither case were the reasons for this documented in the patients notes/CPA records.

5.5 (iii) Comments

Compliance with this standard was good. The audit showed that in most cases patients are receiving the right amount of medication in the right amounts. Two patients who had a history of self-harm were prescribed medication in excess of 14 days without explanation. Prescribing issues were not given a particular focus in *Avoidable Deaths*.

Recommendations

Update prescribers re best practise when prescribing for high risk patients.

5.6 - Standard Six: Co-Morbidity/Dual Diagnosis

1. A strategy exists for the comprehensive care of people with co-morbidity/dual diagnosis. i.e. people with mental health problems who also engage in alcohol and/or substance misuse.
2. Staff who provide care to people at risk of suicide are given approved training in the clinical management of cases of co-morbidity/dual diagnosis.
3. Statistics for co-morbidity/suicide are collected and used to inform decision-making on resources.

5.6 (i) Comment

The trust does not currently have a dual diagnosis strategy but a working group has been convened to address this. Limited training has been given in this area (see standard 8). Routine statistics in this area are not currently collated.

Recommendations

- Develop a strategy for the comprehensive care of people with dual diagnosis, to include an examination of how data on co-morbidity/dual diagnosis can be used to inform decision-making.
- Review needs for training in dual diagnosis as part of training needs analysis and plan (see standard 8).

5.7 - Standard Seven: Post-Incident Review

1. Suicides and serious attempts are reviewed in a multi-disciplinary forum, including as far as possible all staff involved in the care of the patient.
2. All staff, patients and families/carers affected by a suicide or serious attempt are given prompt and open information and the opportunity to receive appropriate and effective support as soon as they require it.

5.7 (i) Data Collection Questions

1. Was a multi-disciplinary review undertaken within two weeks of the suicide/serious suicide event?
2. If no, but a review WAS undertaken please state when.

3. Did key¹ staff involved in the patients care attend the serious incident review?
4. Please state which staff attended the review.
5. Were specific recommendations made as a result of the review?
6. Is there a record of whether a member of staff was given responsibility for ensuring family/carers were offered support and kept informed?
7. Is there a record of whether carers/family were offered support?
8. Was a report of the review produced?
9. If so, was the report shared with the family/carer?
10. Were staff offered support? (If a support protocol exist please attach)
11. What did the support consist of?

5.7 (ii) Study Sample

Initially we agreed to audit all suicides reported to the risk management team between June 2003 and June 2005, in keeping with the audit timescale. This identified 4 cases, 3 known to community mental health services and 1 where the incompleteness of records meant we were not able to identify which part of the service the patient had been under (sample 1).

A brief review of cases in sample 1 highlighted the incomplete nature of the records. It was also noted that during this time period regular post-incident reviews had been suspended (2004).

We decided to increase the timescale of the audit for this standard and looked at suicide reviews undertaken between June 2005-September 2006. This identified a further 4 reviews, 3 cases known to inpatients and 1 case known to community services (sample 2). This gave an overall sample of 8 cases.

5.7 (iii) Results

The results are presented for sample 1 and then sample 2 and then the combined results are presented graphically.

¹ Named nurse / duty staff at time of incident / key MDT staff / Care Co-ordinator / RMO or deputy / Social Worker / Psychologists / Ward Manager

Sample 1 (June 2003- June 2005)

Table 4: responses to Q1-10

| Questions | Yes | No | Blank |
|---------------------|-----|----|-------|
| 1.Review 2 weeks | | 4 | |
| 3.Key staff attend | 2 | 2 | |
| 5.Recommendations | 1 | 2 | 1 |
| 6.Staff responsible | | 4 | |
| 7.Offered support | 1 | 3 | |
| 8.Report | 1 | 3 | |
| 9.Report shared | | 4 | |
| 10.Staff support | | 4 | |

- None of the cases had a review within the two week time period.
- In only half of the cases were the review attended by key staff.
- In only 1 review was a report, with recommendations produced. There was no evidence that this had been shared with family/carer.
- No evidence that staff received support.

Sample 2 (June 2003-June 2005)

Table 5: responses to Q1-10

| Questions | Yes | No | Blank |
|---------------------|-----|----|-------|
| 1.Review 2 weeks | 1 | 3 | |
| 3.Key staff attend | 1 | 1 | 2 |
| 5.Recommendations | 2 | 2 | |
| 6.Staff responsible | 1 | 3 | |
| 7.Offered support | 1 | 3 | |
| 8.Report | 2 | 1 | 1 |
| 9.Report shared | | 2 | 2 |
| 10.Staff support | 1 | 2 | 1 |

- Only 1 case had a review within two weeks. The date of the review was not documented in the 3 other cases.
- In only 1 case did key staff attend the review.
- Reports with specific recommendations were produced after two of the reviews. There was no evidence that the report was shared with family/carers.
- In one case support to staff was documented.

5.7 (iv) Comment

It is clear that over the last 4 years there have been significant challenges in undertaking post-incident reviews, reflecting in part, limited recognition on the part of services, managers and clinicians of the value of this process. There is no standardised report format, which often made extracting information difficult and concise incident reports with robust action plans have been lacking.

Post-incident reviews have not been completed in a timely manner and it has been difficult to identify lead/accountable clinicians or managers responsible for ensuring that learning from the reviews has been secured. There have been difficulties arranging for key staff to attend reviews and conversely some staff report that they have had difficulty inputting into reviews when they felt it would have been useful. There is little evidence that information is shared, where appropriate with family/carers and few are offered support. In addition, there is no documented process to show that staff are offered support during these reviews, which are understandably emotional and stressful.

These findings were presented at a clinical meeting (predominantly psychiatrist) which highlighted a perception that the reviews are undertaken in the context of a "blame culture". Clearly this needs to be addressed.

A clear message from the National Confidential Inquiries is the need to learn from post-incident reviews and ensure that the learning from these procedures is systematised in organisations. *Avoidable Deaths* suggests that we need to reflect on our attitudes to death by suicide and make better recognition of the fact that death by suicide can be avoided and prevented in a significant number of cases.

Recommendations

- Review the protocol/policy for undertaking post-incident reviews.
- Identify a senior clinician to work collaboratively with risk management team and provide senior clinical leadership.
- Examine why reviews have not been completed? not seen as a priority ? lack

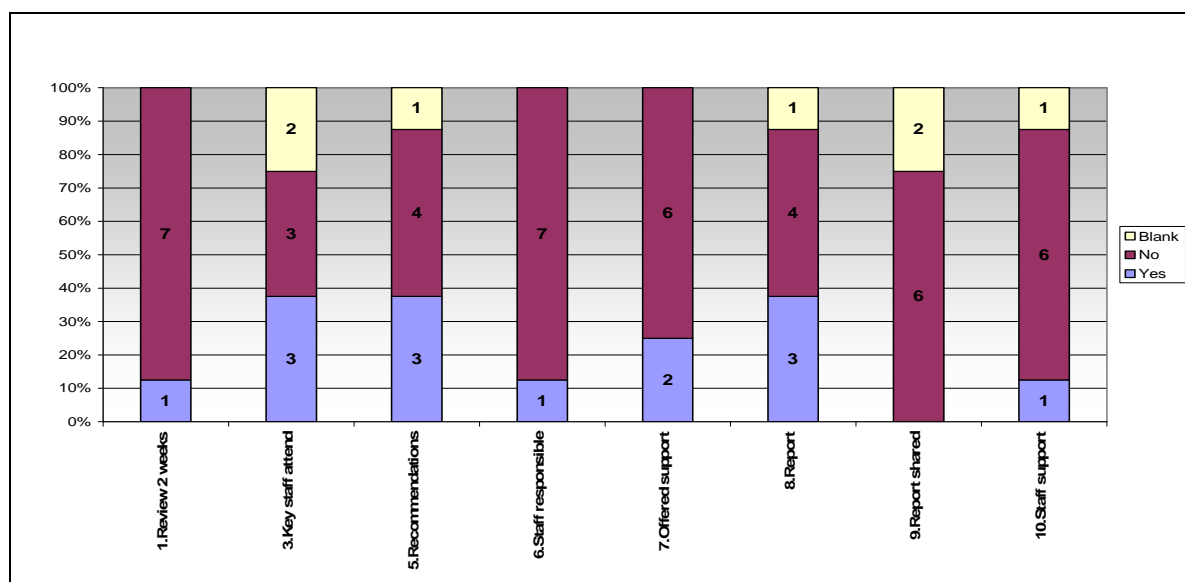
of understanding on part of staff re the purpose of reviews..? lack of clinical leadership.

- Review the notification system for suicides in people known to services (in the period 2003-2005: 14 people known to service committed suicide but only 3 had a review).
- Produce a standardised form/record for documentation and progress chasing of reviews.
- Ensure that reviews are undertaken in a timely fashion.

- Strengthen the performance monitoring framework for completion of reviews.
- Review approach to information sharing with family/carers and the support offered to them.
- Identifiable/documented process for supporting staff involved in reviews.
- Examine how learning from the review process inform staff and service development.

Overall Results (Sample 1 and 2 combined)

Figure 20: Post Incident Reviews-Overall results of Yes/No responses for sample 1 and 2 (n=8)



5.8 – Standard Eight: Training

1. 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 3 years.
2. The training is approved by the organisation.
3. The training is comprehensive and the quality and effectiveness of the training is continuously evaluated.

5.8 (i) Data Collection Questions

1. Are risk-training courses formally approved by the Organisation?
2. Have all staff in contact with patients at risk of self-harm or suicide received training every three years in recognising

of risk, assessment of risk, management of risk. (NB refined this Q see 3a 3b).

- 3a. How many staff members of the statutory Mental Health Services should have received risk training in the last three years?
- 3b. How many of these staff members have received risk training in the last three years.

– 4.6.

Are the following training needs covered by ASW Mental Health Act updates, CPA updates, Section 12 doctor's Mental Health Act updates, Mental Health Act training for inpatient staff, Mental Health Act training for community based staff, STORM updates:

- Indicators of risk.
- High risk periods.

- Managing non compliance
- Managing loss of contact.
- Communication between services, agencies, professionals, users, carers.
- Mental Health Act.

5. What plans are in place to ensure that all care staff are trained every three years (s8)?

6. Are training courses provided on co-morbidity/dual diagnosis (s6)?

7. What training programmes are provided?

8. What is the total number of staff who provide care to patients with dual diagnosis at risk of Suicide (s6)?

9. How many staff members have received approved training in co-morbidity/dual diagnosis in the last three years (s6)?

5.8 (ii) Results

1. Are risk-training courses formally approved by the Organisation?

Yes. Walsall tPCT endorses the use of STORM (Skills based Training on Risk

Management) training and risk management training is included in CPA/clinical risk management update training.

2. Have all staff in contact with patients at risk of self-harm or suicide received training every three years in recognising of risk, assessment of risk, management of risk.

No. Need to define which group of staff this refers to (see 3a and 3b).

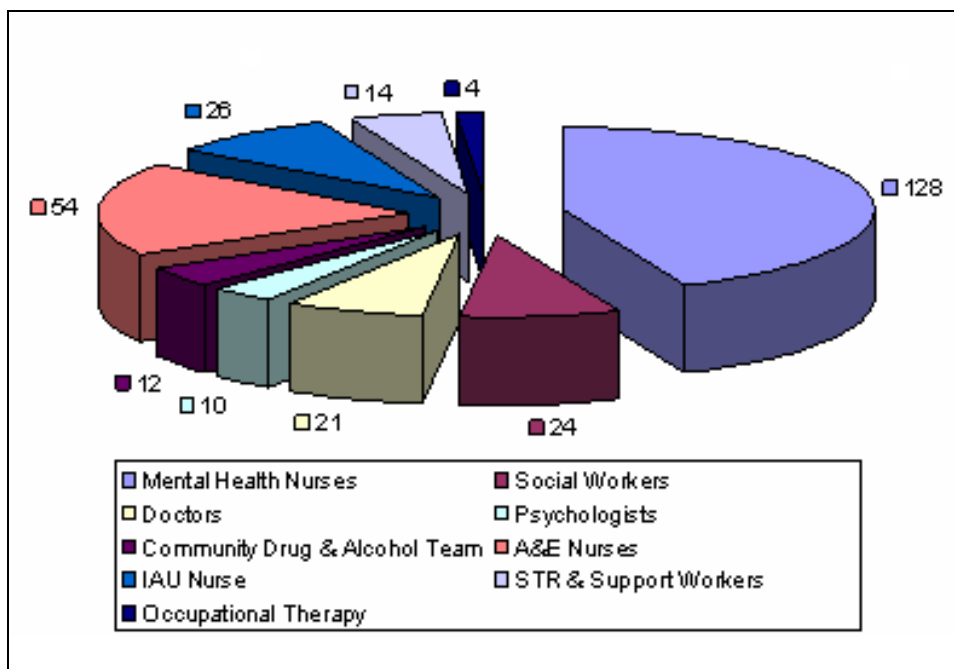
3a. How many staff members of the statutory Mental Health Services should have received risk training in the last three Years.

354

3b. How many of these staff members have received risk training in the last three years.

213 (60.2%). An additional 80 members of A&E and IAU staff have also received training.

Figure 21: STORM July 2005-October 2006 (41 Training Sessions – 293 staff)



4.1 – 4.6 Are the following training needs covered by ASW Mental Health Act updates, CPA updates, Section 12 doctor’s Mental Health Act updates, Mental Health Act training for inpatient staff, Mental Health Act training for community based staff, STORM updates:

- Indicators of risk.

- High risk periods.
- Managing non compliance.
- Managing loss of contact.
- Communication between services, agencies, professionals, users, carers.
- Mental Health Act.

Yes. Training programmes offered to staff cover indicators of risk, high risk periods, managing non compliance, managing loss of contact and communication between services, agencies, professionals, users and carers and the Mental Health Act. (see appendix 1 for more detail re STORM and other training courses offered at Walsall).

5. What plans are in place to ensure that all care staff are trained every three years?

It is not clear whether a training needs analysis has been undertaken and an appropriately funded training plan devised.

6 Are training courses provided on co-morbidity/dual diagnosis?

Yes.

7 What training programmes are provided?

Co-morbidity/dual diagnosis training courses provided for all mental health staff working with service users who have dual needs especially those working in Assertive Outreach, CMHT's and Home Treatment.

The course objectives are as follows:

- Defining the client group.
- Detection and assessment of Dual Diagnosis.
- Prevalence and Risk.
- Treatment outcomes in Dual Diagnosis.
- Harm minimisation and risk management.
- Policy and Guidance.
- Relationship between drugs, alcohol and mental health.
- Models of treatment provision.
- Local typology and care pathways.
- Stages of change model.
- Local service provision.

8 What is the total number of staff who provide care to patients with a dual diagnosis at risk of Suicide (s6)?

Difficulty defining this group meant that an accurate figure could not be given.

9 How many staff members have received approved training in co-morbidity/dual diagnosis in the last three years (s6)?

As of 27th November 2006, 20 members of staff had received approved training in co-morbidity/dual diagnosis. This consisted of 6 social workers, 8 nurses and 6 support

workers all from within mental health services.

5.8 (iii) Issues

- Difficulty defining precisely staff group to whom the standards applied.

5.8 (iv) Summary of findings

- Approved suicide risk assessment training exists (STORM) - main roll out has been last year.
- 60% of eligible staff have received STORM training.
- Lack of robust training data management system.
- Has been difficult to identify which staff groups are eligible for which training.
- From the audit, it was not clear whether a detailed, funded training plan covering the next 3 years is in place.

Recommendations

- Review training needs analysis and focus on risk assessment, management of those at risk of suicide and those with a dual diagnosis.
- Roll out STORM training across mental health service and General Practice and primary care.

Summary – Next Steps

This audit has highlighted some good practise and recognises that local staff are committed and have worked hard to achieve this. However, much remains to be done to achieve compliance across all standards. An action plan has been agreed and is detailed in Table 1.

Performance Monitoring

It was agreed that the Director of Mental Health Services will lead implementation of the action plan from this audit, quarterly reports will be made to the Suicide Review Group and Mental Health Clinical Governance Group.

Table 1

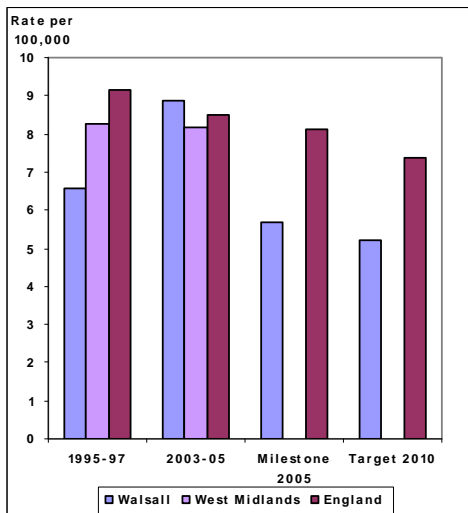
6 CHANGING MINDS – SUICIDE PREVENTION AUDIT OF WALSALL MENTAL HEALTH SERVICES: ACTION PLAN 2007-2008

| Standard | Recommendation | Lead | Timescale |
|--|--|------------------------|------------------|
| 1. Appropriate Level of Care | <ul style="list-style-type: none"> ▪ Produce an action plan for universal implementation of CPA at appropriate levels across the service. ▪ Rolling programme of update training on use of CPA for all clinical staff. ▪ Review integrated note system –include CPA documentation as part of multi-disciplinary notes. ▪ Audit CPA use in 12 months. | Liz Locket Dr Ahmed | 2007-08 |
| 2. In patient Suicide Prevention | <ul style="list-style-type: none"> ▪ Implement annual ligature audits on all wards. ▪ Review action re: door as ligature points. ▪ Maintain high standards of environmental risk assessment. | Jan Scott | 2007 |
| 3. Post-discharge Prevention of Suicide | <ul style="list-style-type: none"> ▪ Ensure the use of multi-disciplinary discharge review meetings and appropriate documentation. ▪ Undertaking suicide risk assessments on discharge from services, transition between services. ▪ Agree and implement a fail-safe discharge follow-up policy. ▪ Review procedure/application of procedure when patients abscond. ▪ Focus on identifying and meeting the needs of patients with dual diagnosis. | Steve Foster | 2007-08 |
| 4. Family/Carer Contact | <ul style="list-style-type: none"> ▪ Review procedures for ensuring family/carers are offered support/information regarding relatives where consent given. ▪ Identify a designated member of post-incident review team to liaise with family. | Jim Warburton | 2007 |
| 5. Appropriate Medication | <ul style="list-style-type: none"> ▪ Ensure all prescribers are aware of prescribing best practise for high risk patients. | Amanda Kelso | 2007-08 |

| Standard | Recommendation | Lead | Timescale |
|---------------------------------------|---|--|-----------|
| 6. Co-morbidity/Dual Diagnosis | <ul style="list-style-type: none"> ▪ Developing a strategy for the comprehensive care of people with dual diagnosis, to include an examination of how data on co-morbidity/dual diagnosis can be used to inform decision-making. ▪ Review needs for training in dual diagnosis as part of training needs analysis and plan (see standard 8). | Gerry Duffy/ Steve Upton | 2007-08 |
| 7. Post Incident Review | <ul style="list-style-type: none"> ▪ Review the protocol/policy for undertaking post-incident reviews. ▪ Identify a senior clinician to work collaboratively with risk management team and provide senior clinical leadership. ▪ Develop a robust suicide surveillance system for Walsall. ▪ Produce a standardised form/record for documentation and progress chasing of reviews. ▪ Ensure that reviews are undertaken in a timely fashion. ▪ Strengthen the performance monitoring framework for completion of reviews. ▪ Review approach to information sharing with family/carers and the support offered to them. ▪ Identifiable/documented process for supporting staff involved in reviews. ▪ Examine how learning from the review process informs staff and service development. | Phil Hogarth/ Dr Susan Lavery/ Judith Preece/ Dr Brian levy | 2007 |
| 8. Training | <ul style="list-style-type: none"> ▪ Review/undertake training needs analysis focus on risk assessment, management of those at risk of suicide and those with a dual diagnosis. | Phil Hogarth/ Steve Upton | 2007-08 |

7 APPENDIX

Table 1: Age Standardised Mortality Rates from Suicide and Undetermined Injury Person, all ages, 1995-1997 to 2002-2005



Compendium of clinical and Health Indicators, 2006

Table 2: Deaths from suicide and undetermined injury, all ages (ICD10 X60-X84, Y10-Y34 exc Y33.9; ICD9 E950-95 and E980-989 excluding E988.8)

| | 1993 | 1994 | 1995 | 1996 | 1997 | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 |
|---|------|------|------|------|------|------|------|------|------|------|------|------|------|
| Number of Deaths by suicide in Walsall | 14 | 18 | 18 | 20 | 14 | 13 | 16 | 21 | 22 | 20 | 14 | 30 | 22 |

Source: Our Healthier Nation Progress Report, 2007

