Impact of NCISH

IMPROVEMENT GOALS

1. To improve the safety of mental health services for all patients;
2. To contribute to a reduction in patient suicide rates and an overall decrease in the national suicide rate;
3. To recommend measures to reduce the number of suicides by people receiving specialist mental health care.

NATIONAL

How the project provides evidence of quality and outcomes of care nationally

Overall fall in mental health suicide: NCISH recommendations associated with 250-300 fewer deaths per year.

Fewer in-patient deaths: removal of non-collapsible ligature points resulting in fall, with trend continuing (though slowing).

Implementation of early follow-up: NCISH recommendation for 72-hour follow-up is a key Commissioning for Quality and Innovation (CQUIN) indicator for mental health trusts in England (2019).

Falls in patient homicide: NCISH data showed a fall in patient homicide overall in 2006-2017.

No evidence suicide increase during COVID-19: Examination of local RTS systems (2020), report accessed >95,000 times.

Highest risk immediately post-discharge: NHS England allocated winter funding to improve the care of post-discharge patients in England following our research (2020/2021 and 2021/2022).

Monitoring the changing pattern of risk: falling numbers of in-patient suicides, rising numbers in CHRT care.

Fall in rate of mental health patient suicide in England: A fall in the patient suicide rate, though the trend is slowing in recent years.

SYSTEM

How the project supports policy development & system management

PHE Local suicide prevention planning

National Suicide Prevention Strategy Advisory Group: Chair (LA), member (NK)

National Suicide prevention:
England 'Suicide Prevention Strategy in England: 5-year cross-sector strategy' (2023).
Scotland 'Creating Hope Together' (2022). Self-harm strategy and action plan (2023)
Northern Ireland 'Protect Life 2 2019-2020' (2019).
Wales 'Talk to Me 2: Suicide and Self-Harm Prevention Strategy for Wales 2015-2020' (2015).

Implementing the NHS Long-Term Plan 2019/20 – 2023/24

CQC guidance development for inspectors: ligature points, early follow up.

Independent commissions:
*Five Year Forward View: Mental Health taskforce (2016);
*Improving acute in-patient psychiatric care for adults in England (2015);
*The King's Fund Mental Heath Under Pressure (2015)

Online Harms White Paper (2020)

NICE Guidelines:
*Self-harm management [CG16 2004; CG133 2011; QS34 2013; GID-NG10148 2022; NG225 2022].
*Preventing suicide in comm. and custodial settings [NG105, 2018].
*Suicide prevention [QS189, 2019].
*Transition between in-pt. and comm. [NG53, 2013].

LOCAL

How the project stimulates quality improvement

Safer Services: a toolkit for specialist mental health services and primary care: based on the '10 ways', designed for self-audit. Accessed >37,000 times

Quality Improvement: working directly with local areas to improve suicide-prevention plans based on NCISH evidence.

Community-based self-harm support: working directly with local areas to improve self-harm care.

Interactive clinics: Themed topics, ~80-150 attendees.

National COVID-19 response: worked directly with all STPs and MH trusts UK-wide to support local suicide prevention.

Safety score card: Annual (England). Provides benchmarked trust position on safer service measures

Trust reviews: analysis of serious patient incidents, evaluation of local suicide prevention policies/strategies.

Standards for Serious Incident Reviews: NCISH standards for reviewing SIs, fed into RCPsych standards (2018).

Self-audit Self-harm toolkit: Based on NICE Quality Standard for Self-Harm [QS34]

Provision of local data to assist audit activity: summary data for trusts on request.

Examples of good practice: Infographics of local suicide prevention initiatives.

PUBLIC

How the project is used by the public and the demand for it

Dissemination (2024 Annual Report)
Annual conference ~600 delegates
Animated video 680 views
Key messages infographic 860 downloads
Service-user infographic 210 downloads

Social media: 9,100+ X(Twitter) followers 26,200 YouTube views

Interactive webinars: COVID-19; Risk Assessment; Children and young people

Government calls for evidence: Men's Health (2023) Women's Health (2021) Suicide Prevention - Sixth Report of Session 2016-2017

Invitations to speak:
International, e.g. Global Health Summit, IASP, ESSSB
Lecture tours, e.g. India, Australia
National, e.g. National Suicide Prevention Alliance
Parliament
Service user groups, e.g. Harmless
Local government
NHS Trust, Public Health
School liaison
Public engagement, e.g. Pint of Science, 9 Lessons & Carols for Curious People

Welsh Assembly: Suicide Prevention Inquiry (2018)

Press/ media coverage: Radio and print interviews, reports in print and online

Impact examples from 2004 to Nov 2024. Impact report updated Dec 2024.

Impact of NCISH: system level

- NCISH has collected **in-depth information** on **all suicides** in the **UK** since 1996.
- Our recommendations have **improved patient safety** in mental health settings and **reduced** patient suicide rates, contributing to an **overall reduction** in suicide in the UK.

- Our **"10 ways to improve safety"** are shown to reduce suicide rates.
- These 10 elements have been formulated into a **self-audit toolkit** for specialist mental health services, updated with new evidence.
- The toolkit has been downloaded **~37,000** times, since launch in 2012.

Our evidence is **cited** in the **latest** national **strategies**, **policies, clinical guidance** and **regulation** in all UK countries.

Suicide Prevention Strategy, England

"Mental health trusts should continue to review and implement evidence-informed recommendations from the NCISH Annual Report and 10 ways to improve safety"

Suicide Prevention Strategy, NI

"NCISH recommends comprehensive care planning…routine follow-up…in response to missed appointments and addressing adverse life and social circumstances…prior to discharge"

Self-Harm Prevention Strategy, Scotland

"…training for staff working in specific settings, safety planning, implementing NCISH recommendations…will help provide the right support at the earliest opportunity…"

NCISH recommendations underpin NICE guidelines

Self-harm: assessment, management and preventing recurrence

Transition between inpatient mental health settings and community or care home settings

NCISH is cited in the Online Harms White Paper, leading to the Online Safety Bill

NCISH recommendations have led to a fall in patient, and in-patient suicide rates